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ABSTRACT

Although the child support enforcement program has been increasingly successful in obtaining health care coverage for children, changes in the labor market, family structure, health care delivery systems, and social welfare policy require new approaches to ensure that children obtain appropriate health care coverage. This report of the Medical Child Support Working Group identifies impediments to the effective enforcement of medical child support, and recommends solutions to these impediments. The report is organized into nine chapters. Chapter 1 addresses the scope of the problem. Chapter 2 provides an overview of the current system from the perspective of the Child Support Enforcement Program (IV-D) as well as from the perspective of the employer and plan community; this chapter also offers a new paradigm for ensuring health care coverage for all child support-eligible children. Chapter 3 offers a detailed analysis and comprehensive reform of how health care is included in a child support obligation and how that order is drafted. Chapter 4 discusses the National Medical Support Notice, the enforcement tool for IV-D medical support orders. Chapter 5 is a broader discussion of enforcement of the health care provisions in a child support order. Chapter 6 discusses improving coordination and communication among private and public health care coverage. Chapter 7 examines funding of child support activities directly related to medical support. Chapter 8 identifies additional strategies and research required to ensure ongoing improvements in assuring health care coverage for children in single parent families. Chapter 9 provides a brief conclusion to the report. Eight appendices include the list of 76 recommendations, a glossary of relevant terms, and a description of the legislative history of major medical support provisions. (KB)

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21 Million Children's Health:
Our Shared Responsibility

The Medical Child Support
Working Group's
Report to

The Honorable
Donna E. Shalala
Secretary
Department of Health
and Human Services

The Honorable
Alexis M. Herman
Secretary
Department of Labor

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June 2000

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Guide to Format of this Report

Chapters at a Glance

The first page of each chapter contains a "chapter at a glance" box (see box for Chapter 1, page 1-1, as sample). This box lists the contents of the chapter, including page numbers, and presents the theme of the chapter. Although a detailed table of contents appears at the beginning of this Report, the list of contents at the beginning of each chapter will help readers locate sections in individual chapters quickly and easily.

“”Quote Boxes

Throughout the chapters, various quotes appear in quote boxes, as shown in the sample here. These quotes comment on and add to the discussion at hand.

> *"Your task is, quite simply, to keep the kids in mind and to think broadly beyond the scope of the work you all individually do to what's a good and workable solution to the issues that face you.... It's not just about the coverage; it's about better health outcomes for the people—for these kids."*
>
> **~Kevin Thurm, Deputy Secretary, HHS**

Cross-References

Cross-references to specific chapters, recommendations, and pages within this Report are highlighted in the margins as shown to the right.

See page x for more information on....

Acronym Reminders

While all acronyms are spelled out and defined in the list of acronyms at the beginning of this Report (see page v below), they are also spelled out and defined upon first usage. In addition, upon first use of an acronym in each chapter, an acronym reminder is provided in the margin as shown here.

PRWORA
Personal Responsibility and Work Opportunity Reconciliation Act

Recommendations

Recommendations are numbered in sequential order throughout the Report and are presented in boxes at the bottom of the sections in which they are discussed. The category/type of each recommendation appears in parentheses following the recommendation number. The body of the recommendation follows. A sample recommendation is shown at the bottom of this page.

Recommendation 1 (Federal Regulation)

The HHS should require each State to maximize the enrollment of children in appropriate health care coverage; the first recourse should be appropriate private coverage of either parent. *("Appropriate coverage" is defined in Recommendation 8.)*

Guide to Format of this Report

Background Boxes

Background information pertinent to the discussion at hand is presented in boxes, as shown in the sample to the right.

Definitions

As necessary, selected terms or phrases are defined in the text in definition boxes, as shown in the sample below ("child support-eligible children"). These and additional definitions may also be found in the Glossary at the end of this Report.

"Child Support-Eligible Children"

As used in this report, child support-eligible children are children under the age of 19 whose parents are divorced, separated, or never-married (and not living together). Not all child support-eligible children live in single parent households, about 17 percent live in married step-parent families. In this report 21 million children living in single or stepparent households are considered to be eligible for child support. Additional child support-eligible children live with a related adult, a guardian or foster parent. Our data is not able to count these children. (See APPENDIX D: Health Care Coverage for Child Support-Eligible Children, page A-32).

History of Federal Funding of the IV-D Program

In 1950, without providing funding, Congress required welfare agencies to inform appropriate law enforcement officials when AFDC was furnished to a child who had been abandoned by a parent. The rationale was to encourage law enforcement officials to take action, including the filing of non-support proceedings against those who had abandoned their children.

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Acronyms Used in this Report

The box below lists all of the acronyms used in this report.

Acronyms

AFDC	Aid to Families with Dependent Children
CCPA	Consumer Credit Protection Act
CSHN	Children with Special Health Needs
CSPIA	Child Support Performance and Incentive Act of 1998
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985
DOL	Department of Labor
HIPAA	Health Insurance Portability and Accountability Act of 1996
HHS	Department of Health and Human Services
ERISA	Employee Retirement Income Security Act of 1974
FFP	Federal Financial Participation
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HMO	Health Maintenance Organization
IV-D Program	Federal/State Child Support Enforcement Program
NAIC	National Association of Insurance Commissioners
NMSN	National Medical Support Notice
NPRM	Notice of Proposed Rule Making
OBRA '93	Omnibus Budget Reconciliation Act of 1993
OCSE	Federal Office of Child Support Enforcement
OIG	Office of the Inspector General
PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act of 1996
PLPW	Poverty Level Pregnant Women Program
PPO	Preferred Provider Organization
QDRO	Qualified Domestic Relations Order
QMCSO	Qualified Medical Child Support Order
SCHIP	State Children's Health Insurance Programs
SDU	State Disbursement Unit
TANF	Temporary Assistance for Needy Families
TPA	Third-party Contract Administrator
UIFSA	Uniform Interstate Family Support Act
URESA	Uniform Reciprocal Enforcement of Support Act
WIC	The Supplemental Feeding Program for Women, Infants and Children

Table of Contents

MEDICAL CHILD SUPPORT WORKING GROUP MEMBERSHIP LIST..........I

GUIDE TO FORMAT OF THIS REPORT..........III

PREFACE/COVER LETTER FROM CO-CHAIRS..........X

EXECUTIVE SUMMARY..........XI

CHAPTER 1. LACK OF HEALTH CARE COVERAGE – HIGH RISK FOR CHILD SUPPORT-ELIGIBLE CHILDREN..........1-1

CHILDREN'S HEALTH CARE COVERAGE IS CRITICAL..........1-1
There Is No Single Reason Why Children Do Not Have Health Care Coverage..........1-2
GOVERNMENT EFFORTS HAVE HELPED BUT MORE NEEDS TO BE DONE..........1-4
CREATION OF THE MEDICAL CHILD SUPPORT WORKING GROUP..........1-7
Legislative Mandate..........1-8
ORGANIZATION OF THE REPORT..........1-10

CHAPTER 2. PARTNERSHIP FOR A NEW MEDICAL CHILD SUPPORT PARADIGM..........2-1

INTRODUCTION..........2-1
How Medical Support Enforcement Works (the Child Support Enforcement Perspective)..........2-2
Procedures Under Current Law for IV-D Implementation of Medical Support..........2-6
How Medical Support Enforcement Works (the Employer and Plan Community Perspective)..........2-6
Current Law Employer and Plan Procedures Necessary for Implementation of Medical Support..........2-8
PRIOR ASSUMPTIONS AND INADEQUATE SOLUTIONS..........2-9
ASSUMPTIONS FOR THE NEW MEDICAL SUPPORT PARADIGM..........2-17
SUMMARY..........2-20

CHAPTER 3. TAKING THE FIRST STEP: ESTABLISHING HEALTH CARE COVERAGE IN CHILD SUPPORT ORDERS..........3-1

STATE CHILD SUPPORT GUIDELINES..........3-1
ROLE OF THE DECISION MAKER – ADMINISTRATIVE AGENCY, COURT, OTHER "TRIBUNAL"..........3-4
Coverage Options – Need for Information..........3-4
Decisionmaking Principles..........3-6
Children with Special Needs..........3-16
The Decision "Matrix"..........3-17
Establishment of Orders for Publicly-Funded or Other Alternative Health Care Coverage..........3-22
Public Payment for Private Coverage..........3-23
Role of the IV-D Agency..........3-24
Enrollment Authority..........3-25

Contribution by the Noncustodial Parent 3-26
Birthing Costs 3-29
Apportioning Responsibility for Unreimbursed Health Care Expenses 3-31
Drafting the Medical Support Provisions of a Child Support Order 3-34

CHAPTER 4. IMPLEMENTING A NEW TOOL: THE NATIONAL MEDICAL SUPPORT NOTICE AND RELATED ISSUES 4-1

NATIONAL MEDICAL SUPPORT NOTICE 4-1
Background 4-1
The Notice and ERISA 4-3
Domestic Violence Issues 4-4
High-Volume Administrative Enforcement 4-4
Timetable: NPRM, Final Rule, State Legislation 4-6
Overview of Notice 4-6
Working Group's Discussion of the Notice 4-8
RECOMMENDATIONS OF THE WORKING GROUP ON MAKING THE NOTICE WORK BETTER 4-10
Program Implementation Issues 4-10
COVERAGE FOR CHILDREN OF FEDERAL EMPLOYEES AND MILITARY PERSONNEL 4-13

CHAPTER 5. ANSWERING HARD QUESTIONS: PROVIDING GUIDANCE TO IV-D AGENCIES AND EMPLOYERS ON ENFORCEMENT ISSUES 5-1

INTRODUCTION 5-1
ENFORCEMENT OF HEALTH CARE PROVISIONS OF CHILD SUPPORT ORDERS 5-2
Enforcing Orders to Provide Family Health Coverage 5-2
Enforcement Issues in Interstate Child Support Cases 5-3
Monitoring and Enforcing Custodial Parent's Responsibility 5-4
CONSUMER CREDIT PROTECTION ACT (CCPA) LIMITS 5-5
Background 5-5
Applicability 5-6
Amount of CCPA Limits 5-7
The Potential for Manipulating the CCPA Limits 5-8
Health Care Coverage for the Child When the Withholding Limits are Breached .. 5-8
PRIORITY OF WITHHOLDING 5-9

CHAPTER 6. MOVING TOWARDS SEAMLESS COVERAGE: IMPROVING COORDINATION AND COMMUNICATION AMONG PRIVATE AND PUBLIC HEALTH CARE COVERAGE 6-1

OUTREACH FOR MEDICAID AND THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM 6-3
SCHIP BARRIERS 6-4
Crowd-Out Policies 6-4
Access to Health Care Coverage 6-6
SCHIP/MEDICAID/IV-D INFORMATION EXCHANGE 6-8
INCREASED EFFICIENCY IN THE COORDINATION OF PUBLIC AND PRIVATE COVERAGE6-12
Automated Data Matches with Private Insurers 6-13
Repeal Mandatory Pay and Chase 6-14

ERISA ISSUES RELATED TO CHILDREN COVERED UNDER QMCSOs 6-17
HIPAA and COBRA *6-17*
Circumstances Under Which Group Health Plans May Impose Preexisting Condition Exclusions *6-21*
Coordination of ERISA Medical Child Support Provisions with Social Security Act Medical Child Support Provisions *6-22*

CHAPTER 7. THE QUESTION OF MONEY: PAYING FOR THE EXPANDED ROLE OF THE IV-D PROGRAM IN OBTAINING HEALTH CARE COVERAGE FOR CHILDREN 7-1

INTRODUCTION 7-1
CURRENT IV-D FUNDING STRUCTURE 7-3
POLICY ISSUES RELATED TO IV-D FUNDING 7-4
Enhanced Federal Financial Participation (FFP) *7-5*
Medical Support Performance Incentive Measure *7-6*
Cross-Program Funding *7-10*

CHAPTER 8. SHAPING THE FUTURE: STRATEGIES FOR ENSURING ONGOING IMPROVEMENTS 8-1

INTRODUCTION 8-1
FINDING NEW SOLUTIONS 8-2
Using the New Hire Process to Collect Health Care Coverage Information *8-2*
Learn More About What Works *8-4*
Developing "Fill the Gap" Coverage *8-7*
BETTER COORDINATION OF POLICIES AND PROGRAMS 8-9
Building Better Partnership for Health Policy Oversight *8-11*
National Policy Coordination Group 8-11
Federal Regulatory Coordination Group 8-12
Containing Health Care Cost *8-13*
Consumer Education and Preventive Health Care *8-13*
REVIEW OF TAX POLICY 8-14

CHAPTER 9. CONCLUSION/POSTSCRIPT 9-1

APPENDIX

APPENDIX A: NEXT STEPS - LIST OF RECOMMENDATIONS ORGANIZED BY TYPE/CATEGORY 1
Federal Legislation *1*
Federal Regulation *6*
Federal Guidance *10*
Technical Assistance/Education *12*
Best Practice *14*
Research and Demonstration *18*
Administrative Action *21*
APPENDIX B: GLOSSARY 23
APPENDIX C: LEGISLATION 28
Legislative History of Major Medical Support Provisions *28*
APPENDIX D: HEALTH CARE COVERAGE FOR CHILD SUPPORT-ELIGIBLE CHILDREN. 32

APPENDIX E: NATIONAL MEDICAL SUPPORT NOTICE 37
Technical Revision Recommendations *37*
Technical Notice Comments *39*
Notice *44*
APPENDIX F: WASHINGTON STATE MODEL NOTICE OF RELEASE FORM 55
APPENDIX G: MEETING SCHEDULE 56
APPENDIX H: MODEL JOINT MEDICAID/SCHIP APPLICATION FORM 59

Preface/Cover Letter from Co-Chairs

At a time when children's health care coverage is the focus of much national attention, children who grow up in divorced, never-married, or separated families are at a greater risk than other children of not having health care coverage. Children without coverage have substantially less access to critical health care services, which are essential for their well-being and productivity.

Although the child support enforcement program has been increasingly successful in obtaining health care coverage for children, changes in the labor market, family structure, health care delivery systems, and social welfare policy require new approaches to ensure that children obtain appropriate coverage—public and/or private.

Recognizing the complexity of the issues involved and the willingness of interested parties to work together, Congress directed the joint establishment of the Medical Child Support Working Group by the Secretaries of Health and Human Services and Labor. The charge of the Working Group, which is comprised of thirty members who represent the broad range of interested and affected parties, was to submit a report to Secretary Shalala and Secretary Herman identifying the impediments to the effective enforcement of medical child support, and recommending solutions to these impediments. The Working Group's Report is an important step in our efforts to increase health care coverage for these children.

The recommendations contained in this Report establish a new model for the medical support enforcement system that puts the needs of children first. The goal in implementing this new model is to increase the number of children with private health care coverage and, for children who cannot obtain appropriate private coverage, to increase their enrollment in publicly-funded health care coverage.

We appreciate the commitment of the members of the Working Group in their efforts to ensure that children in this nation are not without health care coverage merely because their parents do not reside together, and we look forward to working with our partners to make this new vision of medical support a reality.

David Gray Ross *Commissioner,* *Office of Child Support Enforcement,* *Administration for Children and Families, HHS*	*Robert J. Doyle* *Director of Regulations & Interpretations,* *Pension & Welfare Benefits Administration, DOL*

Executive Summary

Opening

For a child, health care is critical. Yet, in the United States today, there are close to over 10 million children without health care coverage. For children who grow up in divorced, separated, or never-married families, the risk of not having health care coverage is great. Of the 21 million children who are eligible for child support enforcement services, approximately 3 million are without health care coverage. These children have substantially less access to health care services, including preventive care that ensures childhood immunizations, vision and hearing screening, and dental care. Health care services are also far more likely to be delayed due to cost. Unmet health care needs reduce a child's ability to grow into a healthy and productive adult.

There is no single reason why children do not have the health care coverage they require. Children, particularly those impacted by the consequences of a family breakup, have not been held harmless from large societal changes: the rising cost of health insurance, the move towards new health insurance models (such as Health Maintenance Organizations) that limit service area and choice of provider, changes in the labor market, the transformation of the American welfare system, and changes in family structure.

Over time, the Federal and State governments have responded to the need for health care coverage for children in two ways. First, they have created publicly-subsidized programs such as Medicaid and, most recently, the State Children's Health Insurance Program (SCHIP). Both programs are need based, primarily serving families with incomes under 200 percent of poverty. Second, the establishment and enforcement of medical child support was added to the responsibilities of the national Child Support Enforcement Program established under Part D, Title IV of the Social Security Act. States are required to include provisions for health care coverage in State child support guidelines and the IV-D program is required to pursue private health care coverage when such coverage is available through a noncustodial parent at a reasonable cost.

Over the past five years a number of legislative changes have strengthened medical child support enforcement and removed some of the impediments to providing children with health care coverage. The Omnibus Budget Reconciliation Act of 1993 (OBRA '93) created the Qualified Medical Child Support Order (QMCSO) and required State laws that prohibit insurers from discriminating in the provision of health insurance when children are born out of wedlock or are outside the insurer's service area. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) required a provision for health care coverage in all child support orders and directed the child support enforcement agency to notify an employer of the noncustodial parent's medical child support obligation.

Despite such reforms, getting and keeping health care coverage for child support-eligible children remains complicated and resource intensive. New strategies and policies are required to make the system easier and more cost effective for parents, employers, health care plan administrators and the government. The goal is both to gain access to better coverage for more of these children and ensure health care coverage for all.

Medical Child Support Working Group -CSPIA & Charge

Congress recognized the scope of the problem and the eagerness of various sectors to address these issues by creating the Medical Child Support Working Group as part of the Child Support Performance and Incentive Act of 1998 (CSPIA). Jointly established by the Secretary of Health and Human Services and the Secretary of Labor, the Working Group was charged with identifying barriers to effective medical support enforcement and developing recommendations that address the following six areas:

- Assess the National Medical Support Notice
- Identify the Priority of Withholding from an Employee's Income, Including Medical Support Obligations
- Coordinate Medical Child Support with Medicaid/SCHIP
- Examine Alternates to a Medical Support Model Focused Exclusively on the Noncustodial Parent's Employer-Provided Health Plan
- Evaluate the Standard for "Reasonable Cost" in Federal Law
- Recommend Other Measures to Eliminate Impediments to Medical Support Enforcement

Working Group Membership - Represents Wide Range Of Sectors

The Working Group is a powerful example of very different worlds coming together, learning each other's languages, developing a greater understanding of legitimate competing concerns, and reaching consensus on real solutions to complex issues.

The Working Group includes thirty members with representatives from the U.S. Department of Labor (DOL), the U.S. Department of Health and Human Services (HHS), State IV-D Child Support Directors and State Medical Child Support Programs, State Medicaid Directors and SCHIP programs, employers, including small business, trade or industry representatives and human resource and payroll professionals, plan administrators and sponsors of group health plans, child advocacy organizations, and organizations representing State child support programs.

The Working Group's greatest challenge was balancing the concerns and interests of the various stakeholders—Federal representatives, State IV-D/Child Support Enforcement, State Medicaid and SCHIP, employers, insurers, plan administrators, child advocates, private attorneys, and representatives of the courts.

Working Group's Principles

The Working Group met eight times since its first meeting in March 1999 and came to consensus on 76 recommendations. Based on testimony and research, the Working Group formulated a package of recommendations with children in the center, based on the idea that the system and structure should work toward what is best for the child. The Working Group was guided by a set of principles, including:

Increase the Number of Children in Single-Parent Households with Health Care Coverage

It is in the best interest of both children and the nation that the maximum number of children have access to health care coverage. Lack of such coverage affects children's current and future health and their ability to become productive citizens.

Appropriate Private Health Care Coverage Comes First

Parents share primary responsibility for meeting their children's needs. When one or both parents can provide comprehensive, accessible, and affordable health care coverage that coverage should be provided to the child. To the maximum extent possible, public dollars through enrollment in Medicaid/SCHIP should not replace private insurance but rather should serve as the payer of last resort where private health care coverage is unaffordable, unavailable, or not comprehensive enough. Public coverage is not intended to relieve able parents of their responsibility to provide health care for their children.

Both Parents are Responsible for Medical Support – Preference to the Custodial Parent (if all is equal) as the Source

Coverage available to both parents should be considered in setting a medical support obligation. Twenty-seven States recognize that both parents may have access to private insurance and direct the decision maker to consider both parents as a potential source. However, nearly half of the States' child support guidelines do not direct the decision maker to consider coverage available to the custodial parent and, as a result, children may be missing out on potential coverage. These recommendations change the child support enforcement's medical support focus, which is now almost exclusively on the noncustodial parent.

Affordable Coverage

In deciding whether to pursue coverage, the cost of coverage is an important consideration. However, the current Federal definition of "reasonable" health insurance—that it is available through an employer—is not necessarily reasonable. The Working Group explored alternative State and Federal definitions, including the SCHIP guidance that the cost of SCHIP premiums should not exceed five percent of a family's gross income, and the applicable Consumer Credit Protection Act (CCPA) limits. The recommendations address concerns that the cost of private health care coverage could significantly lower the amount of cash support available to meet the child's basic needs and the child is eligible for some other form of health care coverage.

Accessible Coverage

When private health care coverage is available to a child, the child support enforcement agency should consider the geographic accessibility of covered services before it decides to pursue the coverage. Given, in particular, the large number of interstate child support cases, the Working Group concluded that children should not be enrolled in any limited provider plan whose services/providers are not accessible to them, unless the plan can provide financial reimbursement for alternate service providers. In its recommendations, the Working Group considers coverage by Health Maintenance Organizations (HMOs), and other plans which limit providers, accessible if the provider may be reached within 30 minutes or 30 miles, but allows States to adopt an alternative standard.

Comprehensive and Seamless Coverage

The child support enforcement program should work in close conjunction with Medicaid and the SCHIP to ensure that children who have access to private coverage obtain such coverage and those who need publicly subsidized coverage are covered by Medicaid or SCHIP.

Overview of Recommendations

The Working Group spent considerable time deliberating, listening to testimony, studying research, and meeting in subcommittees.

The Working Group's deliberations led to 76 recommendations. While many are practical and technical, others are visionary—a dramatic shift to a new paradigm—necessitating fundamental changes to State and Federal government's management and operations of medical child support enforcement. Some of the recommendations are Federal mandates, others are "best practices" to be shared with States, employers, and others. The implementing strategy for each recommendation falls within one or more of the following categories:

- Federal Statute/Legislation
- Federal Regulation/Guidance
- Best Practice
- Technical Assistance and Education
- Research, Evaluation, and Demonstration

Considering the complex interplay of trends in health care delivery, labor market, and family structure, the Working Group has formulated a comprehensive strategy that overhauls the current medical support system for the country's 21 million child support-eligible children. Enactment or adoption of these recommendations will increase the number of children with private health care coverage and increase access to publicly-funded health care coverage for children who cannot obtain private coverage. Throughout, the Working Group recommends a broader, more proactive role and responsibility for IV-D agencies in ensuring that children have health care coverage. As a necessary companion to these mandates, the Working Group recommends immediate enhanced funding to IV-D programs for medical support enforcement. Although the enhanced funding is time-limited, the recommendations also address research and future funding.

The solutions developed by the Working Group are most easily considered in two broad categories: recommendations that ensure seamless health care coverage for all children and recommendations that streamline medical support enforcement. Below is a sampling of the Working Group's 76 recommendations:

Seamless Coverage for All Children

- State child support guidelines are based upon outdated assumptions and therefore fail to maximize private family health coverage enrollment for child support-eligible children. Even when State child support guidelines direct the decision maker to look at coverage available to both parents, this is not always the case. Therefore, the Working Group makes recommendations that require States to adopt medical child support guidelines that require the decision maker to explore health care coverage available to both parents.
- The Working Group developed a "decision matrix" that provides guidance to decision makers when

deciding which health care coverage is the most appropriate—affordable, accessible, comprehensive—to order. This matrix considers private insurance available to both parents and grants decision makers flexibility to order parents to seek public coverage where no private health care plan is found to be appropriate. These important recommendations provide structured and equitable treatment to all children.

- The Working Group recommends that the Federal regulation that deems all employment-related or group-based coverage to be reasonable in cost should be replaced with a standard based on the cost of coverage relative to income of the parent who provides the coverage. If the cost of providing private coverage does not exceed five percent of the gross income of the parent who provides coverage, then the cost should be deemed reasonable.

- The Working Group makes recommendations to improve coordination between IV-D and Medicaid and SCHIP, including adding IV-D as an agency that can engage in presumptive eligibility for Medicaid enrollment.

- The decision maker needs information about health care plans that are available to both parents to determine where there is access to private health care coverage, and how to allocate costs and draft the medical support order. Therefore, the Working Group recommends that States develop discovery mechanisms that require parents to disclose information about health care coverage to ensure the best available health care choice is ordered. In addition, the Working Group recommends further study of automated sources that would provide improved information sharing and data exchange.

- The Working Group recommends that SCHIP eligibility not be denied where a child is enrolled in private insurance but the health care benefits are not geographically accessible.

Streamline Process for Enforcement

- During its deliberations, the Working Group provided significant feedback and input on the National Medical Support Notice. The suggested changes make the Notice more "user friendly" for IV-D personnel, employers, and plan administrators. The Notice of Proposed Rule Making (NPRM) on the Notice, proposed in November 1999, provides a uniform tool for States to inform employers to enroll noncustodial parents' children in an employer-sponsored group health plan. The standardized form has two parts. After an employer receives the entire Notice, the employer retains Part A and sends Part B to the appropriate group health plan. In addition, the Working Group provides recommendations to improve the implementation and use of the Notice through education and outreach strategies.

- The Working Group makes recommendations on the Medical Support Incentive and funding for these new medical support activities. Enhanced Federal Financial Participation (FFP) to jump-start these medical support activities is the key. In addition, the Working Group recommends that two years be afforded to the Medical Incentive Workgroup to finalize the measure, using this time to obtain data not currently available. The incentive would be in place in the third year and States would begin collecting and reporting the data necessary to calculate the incentive. Full implementation of the medical support performance measure would begin at the end of five years, at which time the enhanced FFP would end.

- The Working Group recommends that the priority of child support be: cash support, then health care premiums and current medical support, then arrears, with flexibility.
- The Working Group recommends that State child support enforcement agencies should not pursue recoupment of pregnancy and birth-related costs in Medicaid cases.
- The Working group recommends research examining potential cost savings to Medicaid as a result of the greater role of IV-D in accessing private health insurance and a special grant project testing the use of innovative health care delivery models for child support-eligible children, such as the Sacramento IV-D Kids program.
- The Working Group recommends amending relevant laws to eliminate—or at least reduce—barriers. In addition to looking at the Employee Retirement Income Security Act of 1974 (ERISA), the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Social Security Act, there are important recommendations to review tax policy in several areas to make the Internal Revenue Code more consonant with health care policy.

Organization of Report

This Report will assist policy makers in developing technical and substantive changes to statutes and regulations. It will provide best practice information to States and employers.

The Report is organized into nine chapters. The first two chapters provide an overview and background. Chapter 1 addresses the scope of the problem and Chapter 2 provides an overview of the current system from the perspective of the Child Support Enforcement Program (IV-D), as well as from the perspective of the employer and plan community. This Chapter lays out not only the requirements and suppositions built into current law but also offers a new paradigm for ensuring health care coverage for all child support-eligible children.

A critical step in child support is establishing the child support order. Chapter 3 offers a detailed analysis and comprehensive reform of both how health care is included in a child support obligation and how that order is drafted. Chapter 4 discusses the enforcement tool for IV-D medical support orders, the National Medical Support Notice. Chapter 5 is a broader discussion of enforcement of the health care provisions in a child support order. Chapter 6 is a macro discussion of system coordination. Funding of child support activities directly related to medical support can be found in Chapter 7. Chapter 8 identifies additional strategies and research required to ensure ongoing improvements in assuring health care coverage for children in single parent families. Finally, Chapter 9 provides a brief Postscript/Conclusion to the Report.

Future

The Working Group's recommendations are designed to create an easier, more cost effective, and comprehensive medical child support enforcement system. Suggested strategies and laws will move our society a long way down the road to ensuring that children are protected from the health care consequences of family dissolution. Finally, although it is the Working Group's goal that this Report frame the focus and future direction of medical child support enforcement within the IV-D program, it is our hope that the consensus built here will also provide a model for sorting through the complex interplay of competing interests and move as a society to ensure health and well-being to all America's children.

CHAPTER 1. Lack of Health Care Coverage – High Risk for Child Support-Eligible Children

Children's Health Care Coverage Is Critical

Access to health care services is a complex issue and the focus of frequent debate by scholars, policy makers, headline writers and the general public. As a society, we continue to struggle with the delivery of adequate medical care to all citizens. While opinions and approaches vary, there is universal accord on one issue: for children, health care is critical.

Children without health care coverage have substantially less access to health care services, including preventive care that ensures childhood immunizations are up to date, vision and hearing screening and corrections have occurred, and routine dental care has been provided.[1] Care for uninsured children is also far more likely to be delayed due to cost.[2] Unmet health care needs reduce children's ability to learn and to grow into healthy and productive adults.

Making sure that children stay healthy is an important goal for all segments of society. Healthy children are important to employers because sick children reduce employee productivity. Healthy children are important to the health care industry because they increase profitability. Healthy children are important to public health programs and providers because improving child health is part of their basic mission. Healthy children are important to the child support community because it is responsible for helping to improve the lives of children who live apart from one of their parents. And

CHAPTER 1 AT A GLANCE

CHILDREN'S HEALTH CARE COVERAGE IS CRITICAL, 1-1
  There Is No Single Reason Why Children Do Not Have Health Care Coverage, 1-2
GOVERNMENT EFFORTS HAVE HELPED BUT MORE NEEDS TO BE DONE, 1-4
CREATION OF THE MEDICAL CHILD SUPPORT WORKING GROUP, 1-7
  Legislative Mandate, 1-8
ORGANIZATION OF THE REPORT, 1-10

Theme

Children who grow up in divorced, separated, or never-married families are at risk for not having health care coverage. Private health care coverage is highly related to income and many single-parent households have lower incomes than two-parent households. Even if income is not an issue, it is usually more difficult for parents to coordinate resource investment in their children when they live apart. Recognizing these risks, Congress established the Medical Child Support Working Group (the "Working Group") to make recommendations for improving health care coverage for children.

most important, healthy children are important to parents because they love their children and want them to have the best life possible. Healthy children are important for all of society, because they are our future.

There Is No Single Reason Why Children Do Not Have Health Care Coverage

Many of the issues related to the lack of health care coverage for children are structural. That is, they are related to larger changes in our society. For decades, the cost of health care has been rising at rates higher than inflation. These rising health care coverage costs have made private family health coverage more expensive for both employer and employee. In response to rising health care costs, our society has moved from a health care insurance model where there was usually a choice of providers (often referred to as fee-for-service plans) to extensive use of health care maintenance plans and other types of plans that put limitations on the choice of provider.

In recognition of the reliance that American society has on private group health care coverage, there have also been many legislative and regulatory interventions to try to make the system work better for employers and insurers, as well as for employees and their dependents. These efforts have affected the tax code, regulated employers, made changes in benefit packages and insurance industry practices, and offered coverage protections to certain classes of employees and dependents. All of these efforts have had the laudatory goal of improving health care coverage. However, taken in their totality, these legislative and regulatory changes have not always been consistent with each other, have sometimes created confusion among both the regulators and the regulated, and may have discouraged participation by some employers and some employees in group health care coverage. These efforts may also have had the unintended consequence of increasing health care costs.

> *"I would ask you to remember our focus is uninsured children. But children do not buy health insurance. Parents buy health insurance for their children, and they buy it with the help of employers and through employers. Granted, the children are also covered through the government, but the government is the conduit of money from employers and parents in order to pay for that health coverage. Either way you look at it, it's the parent and the employer, through taxes or directly, that pays for health coverage. And to the extent that health-care coverage is affordable, there's a direct relation to the extent that there will be coverage for the uninsured children."*
>
> **~ Terry Humo, General Counsel, Intermountain Administrators, Inc.**

Changes in the labor market have affected health care coverage as well. It is less likely today for workers to stay in the same job for long periods of time. There are fewer blue-collar jobs with generous benefit packages for low-skilled workers. More workers are working part-time, on a temporary basis, on a contract basis, or are self employed. This may mean that workers do not qualify for health benefits because they work too few hours or have not worked long enough.[3] Individuals whose low level of skills and/or education makes it difficult to move out of the low-wage segments of the labor market are least likely to have coverage. These workers often find that their employers are less likely to offer health care coverage or that, if offered, they cannot afford to take advantage of the coverage.[4]

The changing structure of the family has also had an impact on children's health care coverage. High rates of divorce and non-marital child-bearing have meant that an increasing number and proportion of children live with only one of their parents. Recent studies have shown that children who live in families with two employed parents are more likely to have health care coverage than children who live in one-parent families, even if that parent is employed.[5] Studies have shown that it is often difficult for parents who live apart to work together on behalf of their children.[6] After divorce or a break-up of a romantic relationship, one parent may move a long distance from the other and their children, one or both may get remarried and have multiple family responsibilities, and often acrimony continues to exist from the break-up of the relationship. All of this makes it more difficult for parents to work together for the sake of their mutual children.[7] Additionally, single-parent households often have low incomes. Children in lower-income households are less likely to have private health care coverage and more likely to rely on public coverage than middle- or upper-income children.[8] (See **Child Support-Eligible Children** box.)

There are also changes in the structure of single-parent households. For example, they

"Child Support-Eligible Children"
As used in this report, child support-eligible children are children under the age of 19 whose parents are divorced, separated, or never-married (and not living together). Not all child support-eligible children live in single parent households, about 17 percent live in married step-parent families. In this report 21 million children living in single or stepparent households are considered to be eligible for child support. Additional child support-eligible children live with a related adult, a guardian or foster parent. Our data is not able to count these children. (See APPENDIX D: Health Care Coverage for Child Support-Eligible Children, page A-32).

are not limited to female-headed households. While mothers are still more likely to have sole custody, approximately 15 percent of all custodial parents are fathers.[9] The structure of single-parent households has also been affected by the fact that more parents have shared legal custody for their children. This means that it is the right of both parents to be involved in important decisions, like health care, even when the children reside primarily with one parent. In addition, some parents are deciding to each take primary physical responsibility for one or more of their shared children, and some states are no longer using the term "custody," but instead are allocating "parenting time" between the mother and father.[10] These changes all affect children's access to health care coverage.

Government Efforts Have Helped But More Needs to Be Done

Over time, Federal and State governments have responded to the need for health care coverage for uninsured children in two ways. *First,* Congress authorized publicly-subsidized health care coverage through the Medicaid program in 1965 and then through the State Children's Health Insurance Program (SCHIP) in 1999. Both Medicaid and SCHIP are need based programs, primarily serving families with incomes under 200 percent of poverty. Approximately 61 percent of the children in these programs live in single-parent households.[11] *Second,* in 1984 State child support enforcement ("IV-D") programs[12] were given the responsibility to include medical support establishment and enforcement as part of their child support efforts. States were required to include provisions for health care coverage in their child support guidelines and the IV-D programs were required to pursue private health care coverage when such coverage was available through a *noncustodial* parent at a reasonable cost.[13] All 21 million children under age 19 not living with both their biological or adoptive parents are potentially affected by State child support guidelines.[14] About 13.5 million children are part of families receiving services through the IV-D program.[15]

In 1987 and 1989, the Office of the Inspector General (OIG), Health and Human Services (HHS) published two studies on medical child support that indicated there was room for substantial improvement in child support enforcement program efforts to obtain private health care coverage from noncustodial parents for their Medicaid-eligible children. These studies indicated that only 24 percent of child support orders (for Medicaid-eligible children) included provisions requiring medical support. These studies also indicated that as of 1989, in 48 percent of reviewed cases without a medical support provision, fathers actually had access to dependent coverage.[16]

In a soon to be released follow-up report to assess the child support enforcement program's progress in obtaining medical support for Medicaid-eligible children, the OIG found that as of 1998, 93 percent of child support orders had provisions requiring medical support for dependent children. In addition, the OIG found that undetected dependent coverage available in Medicaid-eligible child support cases from the noncustodial parent through employment had been reduced from the 48 percent noted in 1989 to approximately 30 percent. Finally, the study notes that the change in health care coverage service delivery—from primarily fee-for-service to primarily managed-care—presents new issues for the cost-recovery strategies to be used when Medicaid-eligible children also have access to private health care coverage.[17]

Past efforts have made a difference. Eighty-six percent of child support-eligible children have private or public health care coverage or both.[18] Still, more needs to be done given the critical importance of access to health care for children. In addition to the issue of undetected health care coverage identified in the OIG report discussed above, two recently released Federal government reports indicate that other critical issues are lack of access to employment-based health care by some employees and the cost of health care coverage, especially for lower-wage employees.

In 1998 the General Accounting Office (GAO) issued a report on the availability of employment-based health insurance. This report indicates that while most workers have access to employer-based health care coverage, a substantial minority, 28 percent, do not. Lack of access to coverage is affected by the size of the employer, the type of industry, the status of the employees, geographic location, and the cost of coverage relative to employee wage levels and size of firm.[19]

In the second report, OIG examined the availability of private health care coverage for children receiving Medicaid benefits. This single-State, small-scale study found that health care coverage was not being provided by 45 percent of noncustodial parents because it was not affordable or not available. The report concluded that the State should consider requiring noncustodial parents to contribute towards the cost of Medicaid premiums or to a (lower-cost) statewide health insurance plan for children that the State should establish.[20] Clearly, for some children, alternatives to employer-based health care coverage are still needed.

The National Child Support Enforcement (IV-D) Program

In 1975, Congress added Part D to Title IV of the Social Security Act, thereby creating the child support enforcement, or "IV-D" program. Although the program has been expanded and enhanced many times over the last 25 years, its goals remain to ensure that both parents financially and emotionally support children and to help reduce welfare expenditures. The IV-D program locates noncustodial parents; establishes paternity; establishes and modifies child support orders, including medical support provisions; collects and distributes child support; and enforces medical support provisions in child support orders.[21]

The child support enforcement system is built on a series of partnerships among Federal, State, and local governments, and the judiciary, as well as cooperative relationships with employers and social service agencies. State and Federal legislation establishes the basic framework, while courts, State offices of child support enforcement, the Federal Office of Child Support Enforcement (OCSE), and other public agencies work together to serve the needs of America's children.

OCSE sets program standards and policy, evaluates States' performance, offers technical assistance and training to States, and audits State program activities. The Federal government also pays the predominant share of the cost of funding the program.

Each State has a child support enforcement agency (also called "IV-D agency"). These agencies are housed in varying locations at the election of State government, including the State human or social services department, the Office of the Attorney General, or the State Revenue Department. Some State IV-D agencies provide localized services by operating State-run offices throughout the State. Other States provide local services through contracts with local government entities (e.g., counties, district attorneys) or private contractors. Still other States have a hybrid system of local offices, with some operated by the State and others operated by local government/contractors.

There is also substantial variation between States in what authority is responsible for establishing and enforcing child support orders—including orders for medical support. Whether a court or an administrative agency issues the order, the decision maker must apply the State's child support guidelines and issue an order for income withholding.

Eligibility for IV-D Services

All families may apply for child support services.[22] Families that are receiving Temporary Assistance for Needy Families (TANF) must cooperate with the State child support agency to establish paternity, collect child support, and obtain health care benefits except for "good cause" reasons, such as serious threat of physical violence. There is a similar requirement for Medicaid, except that Medicaid-eligible children cannot be denied for failure to cooperate, and pregnant women eligible under the poverty level eligibility group are not required to cooperate as a condition of eligibility. Families who do not receive public assistance receive services upon application. While the application fee is minimal, States are permitted to recover costs and thus the applicant may be responsible for additional costs or fees.

In 1996, approximately three million children not living with both of their biological or adoptive parents had no health care coverage throughout the year. Some of these children had no private health care coverage available through either their mother's or father's employment. Others had private health care coverage available, but neither the parents nor the local child support enforcement program were able to break through the barriers that make it difficult to get health care coverage for these children. Still others were eligible for publicly-sponsored coverage, but their parents did not know how to apply for coverage or that such coverage was even available. Yet other children had coverage for only part of the year[23] and they, too, needed help filling the coverage gap.

New strategies and new approaches are needed to ensure that children are held harmless from the potential adverse health care consequences of family break-up. All 21 million child support-eligible children will be affected by the recommendations presented in this Report. For these children, getting and keeping health care coverage is complicated and resource intensive. The Working Group believes that the recommendations in this Report will make getting children into health care coverage easier and more cost-effective for parents, employers, plan administrators, insurers and government. If fully implemented, these recommendations will result in more children having the best private health care coverage available through their parents and fewer children having no health care coverage at all.

> *"Your task is, quite simply, to keep the kids in mind and to think broadly beyond the scope of the work you all individually do to what's a good and workable solution to the issues that face you.... It's not just about the coverage; it's about better health outcomes for the people—for these kids."*
>
> **~ Kevin Thurm, Deputy Secretary, HHS**
> **May 12, 1999**

Creation of the Medical Child Support Working Group

Congress recognized both the nature of the problems and the willingness of the various communities to deal with them in a coordinated fashion. To encourage these efforts, it created the Medical Child Support Working Group ("Working Group") as part of Pub. L. 105-200, the Child Support Performance and Incentive Act of 1998 ("CSPIA").[24] Jointly established by the Secretary of Health and Human Services and the Secretary of Labor, the Working Group includes representatives of the Federal government, employers, health plan administrators, the health insurance industry, child support professionals, SCHIP and State Medicaid programs, unions, courts, and advocates for parents and children. These representatives committed themselves to work together to develop solutions that expand health care coverage for children and that are sensitive to the needs of all the stakeholders in the support enforcement arena.

Legislative Mandate

Congress charged the Working Group with developing specific recommendations that address the six areas outlined below. The Working Group was charged with identifying impediments to effective enforcement of medical support by State agencies administering the programs operated pursuant to Part D of Title IV of the Social Security Act.

❶ Notice

Assess the form and content of the National Medical Support Notice (the "Notice," or NMSN), issued under interim regulations.

❷ Withholding Priorities

Propose measures that would establish the priority of wage withholding for current child support, medical support, arrearages, and the employee's portion of any health care coverage premium, in light of consumer protection statutes.

❸ Coordination with Medicaid/SCHIPs

Recommend appropriate procedures for coordinating the provision, enforcement, and transition of health care coverage under State programs.

❹ Alternatives to Health Care Coverage Through the Noncustodial Parent

Recommend measures to increase the availability of alternate types of medical support, in addition to health care coverage offered through the noncustodial parent's health plan and unrelated to the noncustodial parent's employer. These could include establishing a noncustodial parent's responsibility to share the cost of premiums, co-payments, deductibles, or payments for services not covered under a child's existing health coverage.

❺ Reasonable Cost

Recommend whether reasonable cost should remain a consideration (under §452(f) of the Social Security Act).

The statute requires HHS to issue regulations that require States to include medical support as a part of any child support order and enforce medical support whenever health care coverage is available to the noncustodial parent at a reasonable cost.

⑥ Other Measures/Impediments

Recommend appropriate measures to eliminate other impediments to the effective enforcement of medical support orders.

As the list above shows, the CSPIA legislation provided a very specific mandate for the Working Group. This mandate focused activities on improving the enforcement of medical support by State IV-D agencies and provided a list of specific issues that should be addressed by the Working Group's deliberations. The Working Group responded to this charge by framing their recommendations to improve medical support enforcement within the context of a broader vision.

This vision incorporated as its target population all 21 million children under age 19 potentially eligible for child support services, not just those currently receiving services through the IV-D system. State and Federal child support rules and activities affect children whose parents do not use the IV-D child support system as well as those who do. For example, a child support order established as part of a divorce action might be enforced in the IV-D system. It is also important to recognize that families move in and out of the public child support enforcement system. For instance, any parent not on welfare who applies for IV-D child support services can terminate receipt of those services at any time.

🏛 Mission Statement of the Medical Child Support Working Group

The mission of the Medical Child Support Working Group is to identify and address impediments to the effective establishment and enforcement of medical child support and the successful promotion of health care coverage for children who are receiving or are eligible for child support enforcement services under Title IV Part D of the Social Security Act.

Adopted by the Working Group May 12, 1999.

The Working Group concluded that "enforcement of medical support" required securing health care coverage for as many child support-eligible children as possible. This would include establishing medical support when private health coverage is available and appropriate, and securing public health care coverage when private coverage is not an option. Getting and maintaining health care coverage for all child support-eligible children was the ultimate mission of the Working Group's activities. (See 🏛 **Mission Statement of the Medical Child Support Working Group** box.)

The Working Group drew upon the expertise of its members, brought in outside speakers and experts, had access to staff at the Departments of HHS and Labor, shared research and policy papers and reports, and relied on the laws and policies that States have already developed and implemented in framing its recommendations. This Report presents an examination of expanding health care coverage for children from the perspectives and concerns of all the stakeholders, and offers recommendations that the Working Group believes will help expand health care coverage options for all 21 million children at special risk because of their family circumstances.

Overall, the Working Group agreed that although public family health coverage is increasingly available to children who do not have private coverage, child support orders should include—and the child support enforcement program should try to secure—appropriate private insurance whenever possible. This Report thus recommends reforms that will increase children's access to private insurance and will expedite processing of medical support orders. However, since private coverage is frequently unavailable or insufficient, this Report also recommends reforms that will improve the delivery of publicly-provided health care coverage.

Organization of the Report

Chapter organization, as well as the "theme" of each chapter, is summarized below.

Chapter 1: Lack of Health Care Coverage – High Risk for Child Support-Eligible Children

Children who grow up in divorced, separated, or never-married families are at risk for not having health care coverage. Private health care coverage is highly related to income and many single-parent households have lower incomes than two-parent households. Even if income is not an issue, it is usually more difficult for parents to coordinate resource investment in their children when they live apart. Recognizing these risks, Congress established the Medical Child Support Working Group (th "Working Group") to make recommendations for improving health care coverage for children.

Chapter 2: Partnership for a New Medical Child Support Paradigm

The Medical Support Working Group offers a new paradigm for ensuring health care coverage for children. Many of the old notions of how to get children into coverage needed to be examined and discarded in light of the complex interplay of trends in health care, labor market characteristics, public program eligibility and participation, and family structure changes. The new paradigm looks to the private health care coverage resources available from both parents and to the availability of public health care coverage when private coverage is not available; it also gives the IV-D program responsibility for coordination of information between the providers of public and private health care and parents. Only by working in partnership will coverage be expanded and maintained.

Chapter 3: Taking the First Step: Establishing Health Care Coverage in Child Support Orders

The place to start reform is at the beginning, with order establishment. State child support guidelines are required to address how health care coverage will be provided, and it is important that each order include the health care coverage that is best for the child. The guidelines presented in this chapter lay out a matrix that directs the decision maker to consider the entire range of coverage options available to the child, including private coverage from either parent and, when appropriate, public coverage. In determining which coverage is best, the decision maker should consider not only availability, but other factors that influence the likelihood that the child will be appropriately and consistently insured, such as accessibility, comprehensiveness, and affordability. When the child is ordered into the appropriate coverage from the start, it will not only benefit the child, but will also reduce administrative and enforcement activity on the part of the IV-D agency, the insurer, and the parents.

Chapter 4: Implementing a New Tool: The National Medical Support Notice and Related Issues

The National Medical Support Notice is intended to provide a standardized means of communication between State child support enforcement agencies, employers, and administrators of group health plans regarding the medical support obligations of noncustodial parents. The Notice will facilitate the process of enrolling children in the group health plans for which their noncustodial parents are eligible. While the Notice that has been proposed would go a long way towards improving medical support enforcement, there are changes that can be made that will further simplify and streamline the process and make it less burdensome to all the parties involved. Steps also should be taken to make the Notice applicable to the Federal civilian and military health care plans.

Chapter 5: Answering Hard Questions: Providing Guidance to IV-D Agencies and Employers on Enforcement Issues

Because circumstances of families change, orders often seem out of date before their provisions are even put into place. Sometimes orders have to be changed, but often the issues can be solved by having reasonable and realistic enforcement rules that help IV-D agencies and employers apply the provisions of award over time even though individual fact patterns have changed. This chapter includes recommendations for two of the most difficult enforcement issues—the Consumer Credit Protection Act limitation on wage garnishment and the Priority of Withholding—as well as recommendations for other enforcement issues.

Chapter 6: Moving Towards Seamless Coverage: Improving Coordination and Communication Among Private and Public Health Care Coverage

Under the current system it is very easy for children to have periods in which no health care coverage is available. The extent to which this happens could be decreased by building feedback loops into the information flow between IV-D agencies and the public health care providers, Medicaid and SCHIP. Additionally, IV-D, Medicaid, and SCHIP agencies need to be working from a common understanding when obtaining private or public health care coverage or both are in the best interest of the child. IV-D should work with Medicaid and SCHIP, as well as with private insurers, to assure that the child is enrolled in appropriate health care coverage.

Chapter 7: The Question of Money: Paying for the Expanded Role of the IV-D Program in Obtaining Health Care Coverage for Children

To improve the establishment, implementation, and enforcement of medical child support, the Working Group has made recommendations that will considerably enhance the responsibilities of child support enforcement agencies. IV-D agencies may need to undertake significant restructuring in order to incorporate new options, and new tools, into their core functions. Without sufficient resources, the Working Group's recommendations cannot be implemented and many of the identified barriers to medical child support enforcement will remain. This chapter lays out a Federal funding scheme to support, and ultimately reward, successful implementation of these recommendations by IV-D agencies.

Chapter 8: Shaping the Future: Strategies for Ensuring Ongoing Improvements

To give children the opportunity for health care coverage will require the development of new strategies that keep up with the changes in the labor force, health care, family structure, and public programs.

Research and demonstration activities can help improve coordination of coverage, fill gaps, and identify new and better ways to get coverage to children. Collaborations within and among Federal and State agencies can help contain costs, identify problems, and make mid-course corrections. Like the old paradigm for Medical Support, the new ideas presented in this Report will become obsolete; knowledge development and coordinated efforts will keep our joint efforts relevant to changing conditions.

Chapter 9: Conclusion/Postscript

Appendix

Endnotes

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[1] Hoffman, Catherine. *Uninsured in America: A Chart Book.* The Kaiser Commission on Medicaid and the Uninsured (June 1998), 40. See also Weissman, J.S., C. Gatonis, and A.M. Epstein. "Rates of Avoidable Hospitalization by Insurance Status in Massachusetts and Maryland." *JAMA* (1992) 268: 2388-94.

[2] *Child Health Facts: National and State Profiles of Coverage.* The Kaiser Commission on Medicaid and the Uninsured, Figure 10. http://www.kff.org/content/archive/2105/childchart.html#fig10

[3] O'Brien, Ellen and Judith Feder. *Employment-Based Health Insurance Coverage and Its Decline: The Growing Plight of Low-Wage Workers.* The Kaiser Commission on Medicaid and the Uninsured (May 1999), 18. Also see *Employment Based health Insurance: Medium and Large Employers Can Purchase Coverage, but Some Workers are Not Eligible*, HEHS-98-184, General Accounting Office, Washington, D.C. 07/27/98.

[4] *Employment Based health Insurance: Medium and Large Employers Can Purchase Coverage, but Some Workers are Not Eligible*, GAO, HEHS-98-184, General Accounting Office, Washington, D.C. 07/27/98.

[5] Weinick, Robin and Alan C. Monheit. "Children's Health Insurance and Family Structure." *Medical Care Research and Review*, 56:1 (March 1999), 66.

[6] Doherty, William, Edward Kouneski, and Martha Farrell Erickson, *Responsible Fatherhood: An Overview and Conceptual Framework*, Report prepared for the Department of Health and Human Services under contract HHS -100-93-0012, Washington, D.C., 1993; Furstenberg, Frank and Andrew Cherlin, *Divided Families, What happens to Children when Parents Part*, Cambridge, Mass: Harvard University Press (1991); *The Future of Children: Children and Divorce* 4 (1), Spring 1994, Center for the Future of Children, The David and Lucille Packard Foundation; Weitzman, Lenore, *The Divorce Revolution: The Unexpected Social and Economic Consequences for Women and Children in America*, New York: The Free Press (1985).

[7] Weinick and Monheit, 56.

[8] U.S. Department of Commerce, Bureau of the Census. "Children Without Health Insurance." Census Brief CENBR/98-1 (March 1998).

[9] Lyon, Matthew. "Characteristics of Families Using Title IV-D Services in 1995." U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (May 1999), Table 1.

[10] *Connecting with Your Kids: A Guide to Establishing, Modifying and Enforcing Parenting Time in Colorado*, Denver: Colorado Foundation for Families and Children (1999).

[11] See APPENDIX D: Health Care Coverage for Child Support-Eligible Children, page A-32.

[12] In 1975, Congress created the child support enforcement program with the passage of Title IV-D of the Social Security Act, hence the reference to the "IV-D" program. This program provides a Federally-funded and State-administered system through which families may establish, enforce, and modify child support obligations, including medical support. Families receiving TANF benefits are required to cooperate with State or local officials to secure support for their children. Other parents may apply for these services. A more detailed discussion of the IV-D program and its responsibilities with regard to securing medical support is contained in Chapter 2.

[13] 42 U.S.C. §652(f)(1999).

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[14] See data tabulations in APPENDIX D: Health Care Coverage for Child Support-Eligible Children, page A-32.

[15] Lyon (1999), Table 1.

[16] *Child Support Enforcement/Absent Parent Medical Liability*, Office of the Inspector General, Department of Health and Human Services (September 1987) and *Coordination of Third Party Liability: Information Between Child Support Enforcement and Medicaid*, Office of the Inspector General, Department of Health and Human Services (December 1989).

[17] *Medical Support for Dependents Receiving Child Support*, Office of the Inspector General, Department of Health and Human Services (forthcoming, June 2000).

[18] See data tabulations in APPENDIX D: Health Care Coverage for Child Support-Eligible Children, page A-32.

[19] *Employment Based health Insurance: Medium and Large Employers Can Purchase Coverage, but Some Workers are Not Eligible*, GAO, HEHS-98-184, General Accounting Office, Washington , D.C. 07/27/98.

[20] *Review of Availability of Health Insurance for Title IVD Children*, A-01-97-02506, Office of the Inspector General, Department of Health and Human Services, Washington, D.C. (June 1998).

[21]. 42 U.S.C. §§651 et seq. (1999).

[22]. 42 U.S.C. §654 (1999).

[23] Wheaton, Laura, "Noncustodial Fathers: To What Extent Do they Have Access to Employment Based Health Care Coverage?" The Urban Institute (forthcoming, June 2000). Prepared under contract HHS-100-95-0021 for the Department of Health and Human Services.

[24] Pub. L. 105-200.

CHAPTER 2. Partnership for a New Medical Child Support Paradigm

Introduction

Parents, as well as private and public stakeholders, must cooperate to make sure that health care coverage is available to all children. Among the "players" in this complex process are Federal, State, and local child support and health agencies; the U.S. Department of Labor (DOL); judges; court administrators; attorneys; parents' and children's advocates; employers; health plan administrators; members of the payroll and human resource communities; insurance industry representatives; and labor unions.

> *"The Child Support Enforcement Program will put children first by helping both parents assume responsibility for the economic and social well-being, health and stability of their children."*
>
> **~ Child Support Enforcement Strategic Plan, with Outcome Measures for FY 2000-2004**

Thus, laws, policies, and procedures designed to remove impediments to medical support enforcement must emphasize coordination and cooperation among all of these individuals and entities. Given the complexity of the issues and the legitimate, competing concerns of the stakeholders, reform is challenging but necessary if health

CHAPTER 2 AT A GLANCE

INTRODUCTION, 2-1
  How Medical Support Enforcement Works (the Child Support Enforcement Perspective), 2-2
    Procedures Under Current Law for IV-D Implementation of Medical Support, 2-6
  How Medical Support Enforcement Works (the Employer and Plan Community Perspective), 2-6
    Current Law Employer and Plan Procedures Necessary for Implementation of Medical Support, 2-8
PRIOR ASSUMPTIONS AND INADEQUATE SOLUTIONS, 2-9
ASSUMPTIONS FOR THE NEW MEDICAL SUPPORT PARADIGM, 2-17
SUMMARY, 2-20

Theme

The Medical Support Working Group offers a new paradigm for ensuring health care coverage for children. Many of the old notions of how to get children into coverage needed to be examined and discarded in light of the complex interplay of trends in health care, labor market characteristics, public program eligibility and participation, and family structure changes. The new paradigm looks to the private health care coverage resources available from both parents and to the availability of public health care coverage when private coverage is not available; it also gives the IV-D program responsibility for coordination of information between the providers of public and private health care and parents. Only by working in partnership will coverage be expanded and maintained.

care coverage for child support-eligible children is to be maximized.

This chapter describes the medical child support enforcement mechanisms currently in place. While several recently enacted laws will change some of these procedures,[1] some of these recent provisions are not yet effective and therefore not reflected in this discussion. This chapter does, however, describe the way the system will work after implementation of many of these new provisions.

How Medical Support Enforcement Works (the Child Support Enforcement Perspective)

The pursuit of private health care coverage for child support-eligible children has been a requirement of the child support enforcement program since Congress passed the Child Support Amendments of 1984. This provision required that the Secretary of HHS issue regulations requiring that States petition for medical child support in all IV-D cases in which such coverage is available at reasonable cost. In the regulations, HHS defines reasonable cost as any health care coverage available through the obligor's employment.[2] Regulations also require that State child support guidelines take into account children's health care needs when a child support order is established. Every State has enacted a child support guideline that presumptively determines how parents' financial obligations are set.[3] Although the approach is left to the State and varies widely, these guidelines generally address how the child's health care needs are to be met.

The Child Support Enforcement Perspective

The child support enforcement perspective encompasses not just the Federal and State child support enforcement stakeholders but also public programs—such as TANF, Medicaid, and SCHIP—that refer families to child support or whose clients are affected by medical support coverage, as well as the courts and attorneys who are involved in setting and enforcing support orders.

Many of the early legislative efforts were designed to assist in reducing the cost of providing publicly-funded health care coverage through the Medicaid program. All Medicaid beneficiaries applying on behalf of children with a parent living elsewhere were required to assign their medical support rights to the State and cooperate with the child support enforcement program. (This was later modified to exclude pregnant and post-partum mothers). Child support and Medicaid agencies were allowed to enter into cooperative agreements to pursue medical support assigned to the State, and child support agencies were required to notify Medicaid agencies when private family health coverage was obtained or discontinued for a Medicaid-eligible person.[4]

In recent years, important legislative changes have been made to strengthen medical support enforcement. The Omnibus Budget Reconciliation Act of 1993 (OBRA '93) amended the Employee Retirement Income Security Act of 1974 (ERISA), creating the Qualified Medical Child Support Order (QMCSO). This amendment clarified that child support orders requiring the provision of health care coverage could be enforced under ERISA-covered group health plans. Such enforcement is applicable to child support orders with medical support provisions that are enforced directly by the IV-D agencies and the custodial parent. OBRA '93 also amended Title XIX of the Social Security Act to require States to have specific laws that would enhance the eligibility of many children for health coverage under their parents' health plans. The State laws impose requirements on insurers and employers designed to increase enrollment opportunities for children, facilitate the filing of claims by custodial parents, and establish new payment disbursement criteria. In addition, OBRA '93 afforded State Title XIX agencies the authority to garnish wages, salary, and other income, and also to withhold State tax refunds from a parent obligated under a medical support order who has received reimbursement from a third party but has not reimbursed the other parent or the service provider.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) also mandated changes in medical support enforcement. PRWORA requires every IV-D child support order to include a provision for health care coverage, not just to petition for inclusion, as under previous law. This provision had the effect of requiring that medical support be established and enforced in all orders, not just when a Medicaid assignment was in effect. Prior to PRWORA, medical support in non-Medicaid cases was only enforced with the consent of the custodial parent. PRWORA also added a provision to help avoid lapses in children's family health coverage.[5] States must notify the new employer of a noncustodial parent about any existing medical support orders.[6] Upon receipt of a notice from the IV-D agency, the new employer must enroll qualified children in its health plan, unless the noncustodial parent contests the notice. Orders issued to ERISA-covered plans are also subject to QMCSO requirements.[7]

What is The Employee Retirement Income Security Act of 1974 (ERISA)?

ERISA regulates most group health plans that are established or maintained by an employer, an employee organization, or jointly by both. However, ERISA does not cover those plans established or maintained by governmental entities or churches for their employees. Title I of ERISA[8] imposes various duties and obligations on covered plans and their "fiduciaries" (such as the plan administrators). The administrators of covered plans must provide to participants and beneficiaries certain information regarding their plans. Each plan also must provide internal procedures for determination of benefit claims. Those individuals who manage covered plans (such as the administrators), and other fiduciaries with respect to those plans, must meet certain standards of conduct in performing their duties. The Pension and Welfare Benefits Administration of the Department of Labor has principal jurisdiction over these provisions.

Of particular importance to State IV-D agencies is ERISA's preemption of State laws. Subject to certain exceptions (such as the exception related to "qualified medical child support orders" described below) the provisions of ERISA supersede, or preempt, any State laws that "relate to" any ERISA-covered plan. Unless one of the exceptions applies, ERISA-covered plans are not required to follow (or may be precluded from following) such State law. For these purposes, the term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law in any State.

The broad preemption of State law contained in ERISA serves several important functions. Primary among these is to ensure that employee benefit plans are subject to a single, consistent set of rules. Particularly with respect to employers who operate in more than one State and collectively bargained plans whose participants work in different States, differing, and sometimes conflicting, State regulations could make plan design and administration extremely burdensome. A single set of Federal rules has greatly eased the creation and adoption of benefit plans across the country. However, Congress has also recognized that the broad preemption of State laws may, in some instances, cause problems with respect to areas that have traditionally been the province of the States, such as insurance regulation and domestic relations law. Accordingly, several exceptions to preemption have been included in ERISA.

One exception to ERISA preemption is for the application of State insurance laws. In relation to this, it is important to understand that some group health plans ("self-insured plans") provide benefits either from the plan's or from the sponsor's general assets. Other health plans ("insured plans") provide benefits through the purchase of insurance (this generally includes situations in which a plan contracts with a managed care organization for the provision of benefits). Under the preemption exception for State insurance laws, insurance contracts purchased by ERISA-covered plans (and the insurance companies that sell them) remain subject to most State insurance laws, such as those that mandate the provision of particular benefits. Therefore, certain State laws may continue to affect ERISA-covered plans through the insurance contracts they purchase. For purposes of this exception, however, an employee benefit plan will not be deemed an insurer.

Congress later added other important exceptions to ERISA preemption. First, in response to ambiguity regarding the applicability of State domestic relations orders to ERISA-covered plans, Congress amended ERISA in 1984 (the Retirement Equity Act of 1984 [REA]) to permit the division of pension plan benefits in certain circumstances. Specifically, RFA requires plans to pay benefits in accordance with "qualified domestic relations orders," or QDROs. The REA amendments were limited to pension plans. Then, in response to similar issues regarding the applicability of medical child support orders to ERISA-covered group health plans, Congress amended ERISA in 1993 (OBRA 93) by adding §609(a), which requires group health plans to provide benefits in accordance with certain State court and administrative orders that provide for health coverage of children of plan participants (QMCSOs). The QMCSO provisions were modeled on the QDRO provisions.

Section 609(a) has been amended several times, most recently by CSPIA and the Balanced Budget Act of 1997 (BBA) in an effort to bring the QMCSO requirements into accord with the standards of Title IV-D of the Social Security Act. For instance, the BBA amended §609(a) to provide that a notice that is issued through an administrative process established under State law, and that has the force and the effect of law, and that provides for medical support for a child of a participant in a group health plan as described in §609(a) would be a QMCSO, provided that the other requirements of §609(a) are met. CSPIA further mandated the joint development of the NMSN that will result in a uniform notice that will be used by all states and local child support enforcement agencies, and that plan administrators must deem a QMCSO when it is appropriately completed. This will assist the States in automating their processes, as well as assuring plan administrators that the Notice they receive from IV-D agencies will be uniform in structure and content, reducing the confusion that currently exists regarding the adequacy of the notices used by such agencies. States are mandated to begin using the NMSN by October 1, 2001.

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Making changes in ERISA consistent with PRWORA, the Balanced Budget Act provided that the name and address of a State or local official could substitute for the address of a child named in a QMCSO, and that administrative notices issued by child support enforcement agencies to enforce medical support provisions of child support orders could be recognized as QMCSOs.[9]

CSPIA
Child Support Performance and Incentive Act of 1998

CSPIA made additional changes to the medical support provisions of Title IV-D. These provisions eliminated the requirement that States pass laws to ensure the continuation of coverage due to employment changes, instituting instead the use of the NMSN to be implemented through regulations issued by HHS and DOL. The development and mandated use of the Notice was intended to make medical child support enforcement more amenable to the highly automated processes being developed for use for other child support enforcement actions. Federal laws that relate to the child support enforcement agencies' medical support responsibilities are contained in various sections of Titles IV and XIX of the Social Security Act.[14]

NMSN
National Medical Support Notice

Federal requirements currently in effect relating to medical child support are presented below.

What is a Qualified Medical Child Support Order (QMCSO)?

In order to be "qualified" (i.e., to be a QMCSO) within the meaning of §609(a) of ERISA, a medical child support order must clearly specify: (1) the name and last known mailing address (if any) of the participant and the name and mailing address of each child covered by the order; (2) a reasonable description of the type of coverage to be provided, or the manner in which the coverage will be determined; and (3) the period to which the order applies.[10] A qualified medical child support order cannot require a group health plan to provide any type or form of benefit, or any option, not otherwise provided under the plan, except to the extent necessary to comply with a State law described in §1908 of the Social Security Act.[11]

Section 1908 of the Social Security Act, which, like the QMCSO provisions, was enacted as part of OBRA '93, specifies certain laws that States are required to enact in order to qualify for Medicaid matching funds. The §1908 laws generally increase the availability of family health coverage to children. For example, some of these laws prohibit an insurer (defined to include all group health plans) from denying enrollment of a child under the coverage of the child's parent on the ground that the child was born out of wedlock, is not claimed as a dependent on the parent's tax return, or does not reside with the parent or in the insurer's service area.[12] Others set rules for insurers and employers to follow when a parent is ordered by a court or administrative agency to provide health coverage for a child and the parent is eligible for health coverage through that insurer or employer.[13] Congress also amended ERISA so that preemption of the §1908 State laws is explicitly lifted to the extent they apply to a QMCSO.

Procedures Under Current Law for IV-D Implementation of Medical Support

❶ Establishing a Medical Support Order

- Require disclosure of health care coverage in all support proceedings.
- Include a provision for health care coverage in every order.
- Consider the availability of health care coverage from noncustodial parents.
- Ensure that health care coverage must be provided regardless of restrictions such as seasonal enrollments, residence of the child, or marital status of the parents.
- Determine, if participant not enrolled and not specified in the order, in which benefit plan to enroll participant.

❷ Enforcing Medical Support

- Develop system for monitoring whether or not employer-based health care coverage as ordered by the court or administrative agency is obtained by the noncustodial parent.
- Enforce health care coverage by administrative notice.
- Ensure that the administrative notice is immediately issued upon an order being entered that requires coverage and thereafter, anytime a noncustodial parent employer becomes known (for example, through a New Hire lead, employment verification, etc.).
- Monitor and enforce employer compliance with the administrative notice.

❸ Communicating Availability of Health Care Coverage

- Establish procedure for the State to communicate the availability of health care coverage through the noncustodial parent's employer (that is, name and address of insurance carrier, type of coverage, group number, and policy number) to the Temporary Assistance to Needy Families (TANF) and Medicaid programs for public assistance-related cases and to the custodial parent.

How Medical Support Enforcement Works (the Employer and Plan Community Perspective)

Private health coverage through an employment-based group health plan is a significant benefit available to many employees. Employers often make health care coverage available as part of a package of benefits offered to some or all of its employees. This benefit package helps employers compete for and retain the workers they need. Cost and competitiveness are twin factors that help

The Employer and Plan Community Perspective

The employer and plan community perspective includes the U.S. Department of Labor, employers, and other entities such as health plan administrators and payroll administrators, insurance industry representatives and regulators, and labor unions.

employers decide what benefits to make available to their employees. Employers generally have discretion in deciding whether to establish a group health plan and in designing various aspects of the plan, such as eligibility and participation requirements and types of available benefits. Most group health plans maintained by private employers for their employees are subject to the provisions of ERISA. Contracts between plans and insurers (including Health Maintenance Organizations [HMOs]) may be governed by State insurance regulators.

Because of the broad scope of ERISA "preemption," whether a group health plan is subject to ERISA will determine the extent to which the plan will be subject to various State laws, including those related to medical child support, and whether enforcement of a medical support obligation requires a QMCSO. ERISA also contains certain provisions related to continuation and portability of health coverage that were added by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), respectively. COBRA and HIPAA also added corresponding provisions to the Internal Revenue Code and the Public Health Services Act.[15]

☞ For more information on HIPAA and COBRA, see CHAPTER 6, page 6-17.

Under the current medical support system, the IV-D program's point-of-contact is the employer, but it is generally the plan administrator who makes the determination of whether a medical support order is qualified under ERISA and notifies the employee, the custodial parent, and the IV-D agency accordingly.

An employer who maintains a group health plan generally has discretion in designating the party that will act as its plan administrator.[16] In some cases, the employer may act as plan administrator. In other cases, an unrelated party may act as plan administrator. The latter is common in plans established pursuant to a collective bargaining agreement. In addition, the plan may employ a third-party contract administrator (TPA) to carry out the administrative functions of the plan.

ERISA-covered group health plans must provide benefits under any medical child support order, including the new NMSN, that meets QMCSO requirements. Such an order must be submitted to the plan administrator to determine whether it is "qualified." Each such plan also must have reasonable written procedures available to all parties for determining whether medical child support orders are qualified, and for administering the provision of benefits in accordance with such orders. Upon receipt of a medical support order, the plan administrator must promptly notify the participant and each child named in the order that the order has been received and indicate the process that will be used to determine if the order is qualified. Within a reasonable time after receipt, the administrator must determine whether the order is qualified and notify the participant and each child named in the order of its determination.

☞ See insert box "NMSN or QMCSO: What's the Difference?," page 4-3.

It is important to note that qualification as a QMCSO is not limited to orders that are established or enforced under the Title IV-D program nor to orders issued in the State where the employer normally does business. Plans have to provide the same benefits pursuant to any child support order that meets the ERISA definition of qualified. This means that plans (sometimes through their sponsoring employers) receive medical support orders (including administrative notices based on an underlying support order) from IV-D agencies, from private lawyers acting on behalf of clients, from noncustodial parents who want to enroll their children in their health benefit plan, and from custodial parents directly in situations where the noncustodial parent is unwilling to enroll the child(ren) as directed in the order. Because population mobility is high, the order or administrative notice may be issued in a State different from the one where the worker and employer currently have residence.

After an order is determined to be qualified, the administrator then notifies the employer or the employer's payroll agent of the premium amount to be withheld from the employee's wages or salary.

The Federal laws that relate to the employer's and plan's medical support responsibilities are contained in ERISA, Titles IV and XIX of the Social Security Act, the Public Health Services Act and Internal Revenue Code.[17] Understanding how these provisions and procedures all fit together is difficult and the varied requirements of ERISA,[18] COBRA,[19] and HIPAA[20] can easily confuse employers, plan administrators, child support agencies, courts, private attorneys, and parents trying to implement medical child support orders.

Key provisions and procedures relating to medical child support, which the employer and plan community must implement in order to comply with Federal law, are presented below.

Current Law Employer and Plan Procedures Necessary for Implementation of Medical Support

❶ Employer Responsibility[21]

- Provide information under private discovery or at the request of the IV-D agency about the employee's eligibility for or enrollment in dependent health care coverage.

- For any qualified order, deduct premiums from employee's pay (not to exceed the Consumer Credit Protection Act [CCPA] limits).

❷ Plan Administrator Responsibility[22]

- If not provided as part of the discovery process when establishing an order, provide information under private discovery, or at the request of the IV-D agency, about the employee's eligibility for or enrollment in dependent/family health care coverage.
- Upon receipt of a medical child support order, promptly notify the participant and each child named in the order (and the IV-D agency if appropriate) that the order has been received and indicate the process that will be used to determine if the order is qualified.
- Within a reasonable time after receipt, determine whether the order is qualified and notify the participant/employee and each child named in the order (and the IV-D agency if appropriate) of its determination.
- Provide immediate coverage without regard to "enrollment season" restrictions or other factors, such as born out of wedlock, not claimed as dependent for income tax purposes, not living with parent, living outside insurer's service area.
- Provide a method for custodial parent to enroll the covered children in the plan (if noncustodial parent refuses to enroll), to obtain benefits, file claims directly, and receive payments.
- Make benefit payments to custodial parent, or child, if they paid expenses.
- To not terminate coverage unless the order is not in effect or dependent child is being enrolled in another plan.

Prior Assumptions and Inadequate Solutions

The Working Group looked at the assumptions that underlie the current medical support model and identified five outdated assumptions about private dependent health coverage that appear to limit the development of a system that can ensure health care coverage for all child support-eligible children. These assumptions are:

❶ Custodial parents are not employed, therefore, only noncustodial parents can provide employer-based health care coverage.

❷ Noncustodial parents are employed at the same job for most of their working lives; therefore, once established, health care coverage will be stable.

❸ Employer-provided dependent health care coverage is free or nearly free to employees; therefore, the cost of employer-provided dependent health care is reasonable.

❹ Private family health coverage is fully portable, that is, it can provide health care coverage for the children even when children and the parent with coverage live far apart. Accordingly, the type of coverage offered and the geographic location of parent and child do not have to be taken into account.

❺ The majority of children receiving publicly-funded health care (Medicaid and SCHIP) have noncustodial parents who could provide private health care coverage as an alternative to public funded care; therefore pursuit of private health care coverage will reduce the number of children on Medicaid and SCHIP.

❶ Prior Assumption #1: Custodial Parents Are Not Employed and Do Not Have Access to Health Care Coverage

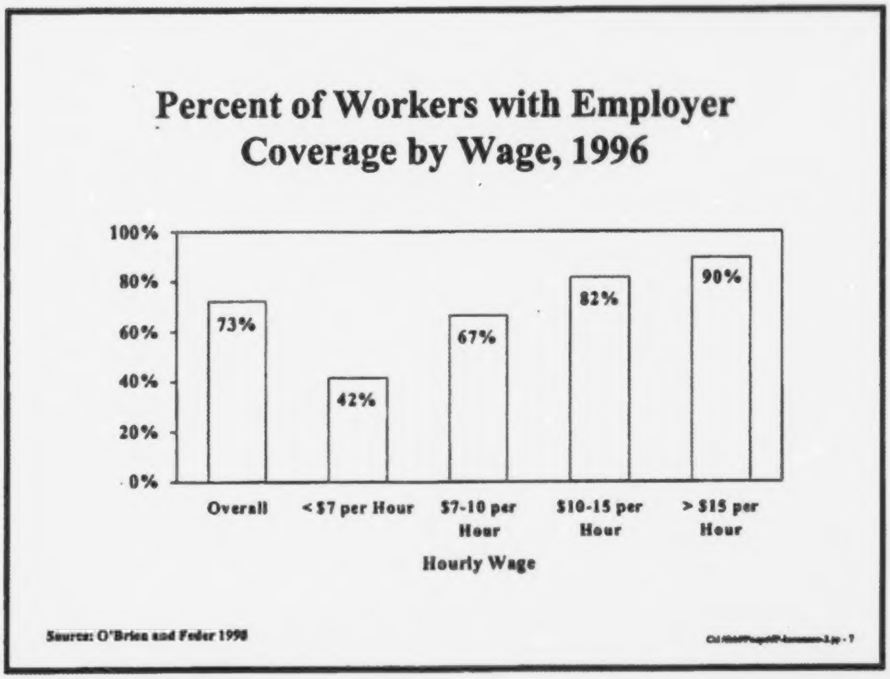
In contemporary society, most custodial parents participate in the paid labor force—by choice, financial necessity, or the imposition of public policy—and thus may have access to family health coverage. In 1995, over three-fourths of all custodial parents were employed during the year and 48 percent were employed for a full year, on a full-time basis.[23] Because private, employer-based insurance is the predominant form of health care coverage in the United States,[24] when parents are employed they are more likely to have private health care coverage. For example, households with two employed parents are more likely to have family health coverage than two-parent households with only one employed parent, presumably because having two workers increases the likelihood of at least one parent having employment-based health care coverage.[25] But when the custodial parent is employed, children in single-parent households also have access to family health coverage. On average, over half of all children in employed single-parent households are covered by dependent health care coverage and an additional one-quarter are offered health care coverage but have not enrolled.[26] In single-parent households with incomes over 200 percent of poverty, more than 60 percent of children are covered by family health coverage provided by the custodial parent.[27] As custodial parents' full-time, full-year participation in the workforce increases, their access to dependent health care coverage also increases.

❷ Prior Assumption #2: Employment and Health Care Coverage are Stable

Some custodial and noncustodial parents have seasonal employment, part-time employment or frequently move from job to job. Even regular full-time employees typically change jobs as their children grow up. In 1998, median employee tenure (the number of years workers have been with their current employer) was approximately three and a half years.[28] Estimates of job turn-over within the IV-D noncustodial parent population are even more frequent. For example, in one study, the median length of time for a wage assignment was 11 months. Termination of employment is the usual basis for termination of a wage-assignment.[29] Obviously, stability of employment affects stability of health care coverage as well. In a review of custodial parents' reports of health care coverage by the noncustodial parent, of the 2.5 million noncustodial fathers who provided health care coverage in at least one month of the year, about two-fifths, or 42 percent, provided coverage in all months.[30] Of the remaining, about one-fifth lost insurance during the year, one-fifth gained insurance during the year, and one-fifth were in and out of coverage several times.[31] This coverage churning reduces access for the children and increases administrative burden for the IV-D agencies.

❸ Prior Assumption #3: Dependent Coverage Is Available and Costs are Reasonable

The majority of employers offer dependent health care coverage to their employees, but eligibility often is limited based on length of employment, hours worked, or employment status.[32] Health care coverage is typically available only to permanent, full-time, year-round employees. Part-time and temporary employees are usually not extended benefits under the employer's health care plan.[33] Low-wage workers are most likely to be part-time, temporary workers, which makes them ineligible for coverage. Indeed, data show that low-wage employees are not offered family health coverage as often as higher-income employees.[34] In 1996, 42 percent of workers who earned less than $7.00 an hour had access to employer-sponsored family health coverage, while 90 percent of those who were paid more than $15.00 per hour benefited from employer-sponsored health care plans.[35] (See graph, **Percent of Workers with Employer Coverage by Wage, 1996.**)


Percent of Workers with Employer Coverage by Wage, 1996

Source: O'Brien and Feder 1998

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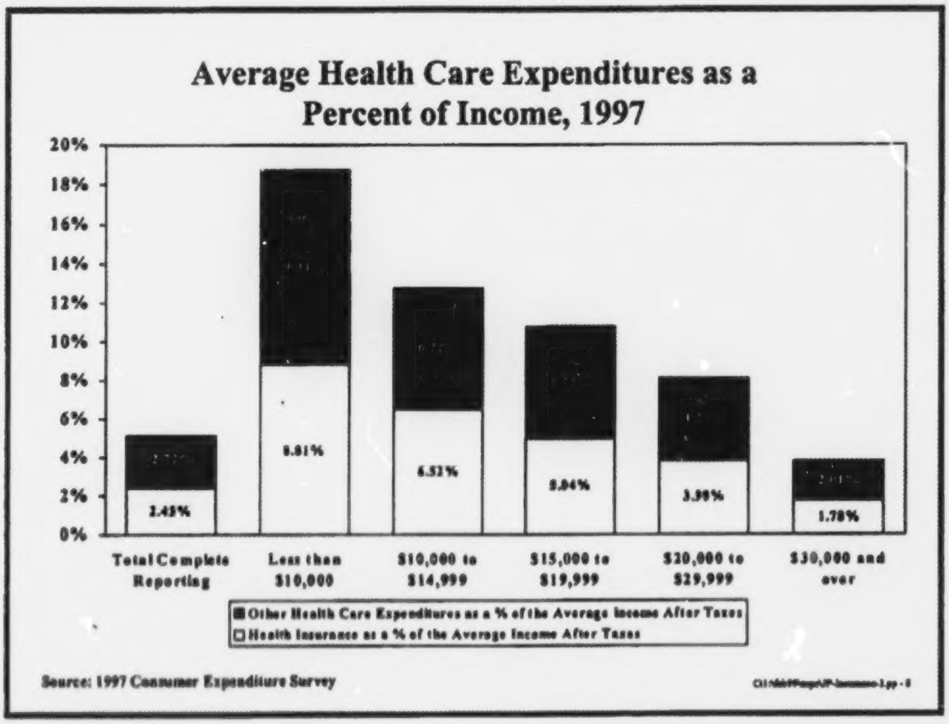
When family coverage is offered, employees may not enroll their children because—even when subsidized by the employer—the employee's share of the premium may be too high relative to income. This is particularly true for low-wage employees.[36] According to an HHS analysis of Consumer Expenditure data, the employee's contribution to health care coverage cost represents less than two percent of after tax income for families with incomes of more than $30,000 but nine percent of after-tax income for families with income of less than $10,000 per year.[37] (See graph, **Average Health Care Expenditures as a Percent of Income, 1997.**) Because of rising health care costs, employers have tended to reduce coverage or to increase the amount of the employee's contribution. For example, from 1988 to 1996 the per capita cost for employers to obtain employee coverage rose by eight percent, while employee contributions to those costs increased by 18 percent.[38] During the same time period, the median earnings of American households increased less than two percent.[39] Such trends put health care coverage enrollment for low-income parents in competition with earnings needed for food, clothing, shelter, and, if a noncustodial parent, payment of child support.

Custodial and noncustodial parents of child support-eligible children fall


Average Health Care Expenditures as a Percent of Income, 1997

Source: 1997 Consumer Expenditure Survey

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disproportionately into the income categories of individuals who have less access to employer-based health care coverage and less ability to pay for coverage, even if offered. As "Percent of Workers with Employer Coverage by Wage, 1996" graph indicates, over one half of individuals making less than $7.00 an hour, or below $14,500 per year, do not have employer-based coverage, and a third of individuals earning between $14,500 and $20,000 do not have coverage. Almost 45 percent of all custodial parents have incomes below $20,000. For custodial parents in the IV-D system that proportion is even higher–about 55 percent.[40] While noncustodial parents have slightly higher incomes, a significant minority, about 38 percent, have incomes below $20,000 per year. While it is not possible to know from existing survey data which noncustodial fathers are associated with children in the IV-D system, an examination of noncustodial and custodial parent characteristics, such as race and ethnicity, marital status, and education would lead to an expectation that, like the custodial parents in the IVD system, the IV-D client noncustodial parents are also slightly poorer than the typical noncustodial parent.[41]

> *"IV-D agencies have the ability to help families identify the best choices for health care coverage. This coverage should include using a case triage as follows, see what kind of insurance would work best for your family:*
>
> - *which parent has family health insurance at no cost; if none, then*
> - *which parent has family health insurance at the lowest cost or determine if the custodial parent wishes to provide insurance coverage and if she/he is willing to pay a higher premium to ensure stability of coverage......; if none, then*
> - *are these parents eligible for Medicaid or CHIP coverage for the children; if no, then*
> - *use a medical support schedule which divides the cost of heath care between the parents.*
>
> **~ Geraldine Jensen, National President, ACES**

Prior Assumption #4 : Distance Doesn't Matter

One of the pervasive problems of the child support enforcement system has been how to handle interstate cases.[42] But the interstate perspective does not just affect collection of cash support; it also affects the provision of health care coverage. Between 25 and 30 percent of all noncustodial parents live in a different State from their children.[43] An additional 20 percent of fathers live in the same State, but not the same county or city as their children.[44] When health care coverage was primarily offered through fee-for-service plans, this long-distance relationship complicated establishing and enforcing medical support, but it did not by

What is Medicaid?

Overview

Medicaid, the largest health insurer in the United States, provided health coverage for 20.8 million children in 1998. Annual Medicaid expenditures for American children (including premium payment for prepaid health care) were $26.2 billion, an average of nearly $1260 per enrolled child.[45] Approximately 40 percent of children who are eligible for IV-D services participate in the Medicaid program.[46]

Medicaid Eligibility

There are several mandatory and optional Medicaid eligibility pathways for children and low-income families. The primary mandatory pathways for children include: coverage for infants under age one (and pregnant women) with family income at or below 133 percent of the Federal poverty level (some States are required to cover children in this group up to 185 percent of the Federal poverty level because they were already providing coverage at the higher level); coverage for children age one to six with family income at or below 133 percent of the Federal poverty level; and coverage for children born after September 30, 1983 who have not attained age 19 with family income at or below 100 percent of the Federal poverty level. States can expand coverage under these groups to children in families with higher income; this is possible under authority which allows them to disregard more income in the eligibility determination than is the case under the usual rules.

The primary pathway for coverage of low-income families with dependent children (including two-parent families) is the so-called "§1931 eligibility group" (§1931 of the Social Security Act). Coverage under this group is linked to certain requirements the State had in effect on July 16, 1996 under the former Aid to Families with Dependent Children (AFDC) program. The State has the option to use certain less restrictive requirements, such as less restrictive financial requirements, than were in effect on July 16, 1996.

Families that lose coverage under §1931 because of hours of work or income from employment (or loss of the earned income disregard) must be provided extended Medicaid benefits ("transitional Medicaid") for six months. A second six-month period of coverage must be provided to any family who received transitional Medicaid during the initial six-month period, as long as the family meets certain reporting requirements and has earned income (minus necessary child care expenses) that does not exceed 185 percent of the Federal poverty level for the size of the family. To be eligible for transitional Medicaid, a family must have received Medicaid under §1931 in three out of the preceding six months before becoming ineligible under this category.

In addition, States must provide Medicaid coverage to all pregnant women, infants, and children up to six years of age, as long as their family incomes are at or below 133 percent of the Federal poverty level for a family of three.[47] In 2000, this cut-off point was $18,819.50.[48] Some States cover all children under age 19 to higher percentages of poverty.[49]

Medicaid eligibility is not affected by an individual's enrollment in private health care coverage. When there is private coverage, individuals can still receive service through the Medicaid program, however, the Medicaid program is the payer of last resort. That is, the private health care coverage is responsible for payment of services. Medicaid only pays for those services not covered under the private plan.

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itself affect the accessibility of that coverage for the children. The custodial parent could take the children to any doctor and the doctor, parent. or Medicaid agency would be reimbursed for the cost of care.

Changes over the last decade in the way health care is provided have made "distance" a larger issue. In 1996, only 27 percent of enrollees in employer health care plans were enrolled in conventional or fee-for-service coverage. About one-third of enrollees were enrolled in HMOs and slightly more than 40 percent were enrolled in other managed care plans that had some provider choice limitations.[50] In these plans, "out-of-network" providers could be used, but with higher cost sharing or lower level of coverage. These trends reduce the utility of having the out-of-State or out-of-area noncustodial parent be the preferred parent to obtain private health care coverage. To complicate the story, these trends vary significantly across the country. For example, 68 percent of enrollees in California are in HMO plans, while only 12 percent of enrollees in North Dakota have HMO coverage.[51]

❺ Prior Assumption #5: Most MEDICAID/SCHIP Enrolled Children Could Have Private Coverage

There is not much difference in the availability of employment-based health care coverage for custodial and noncustodial parents when employment and income are taken into account. As full-time employment increases and income rises, private health care coverage becomes more available and more affordable. To the extent that noncustodial parents have more full-time employment and higher incomes than custodial parents, they are likely as a group to have more access to affordable private health care coverage. However, to the extent that some custodial and noncustodial parents share similar barriers related to employability, such as inadequate education, low job skills, or substance abuse problems, their lack of access to private health care coverage will be similar.

A recent HHS study looked at the potential for noncustodial parents (only fathers) to provide private health care coverage for their children. The ability of the *noncustodial* parent to provide for such coverage was found to be largely dependent on the individual's income.[52] Nearly half of the noncustodial parents who do not provide coverage for their children do not have access to employer-sponsored dependent health care coverage, are self-employed, not employed, or incarcerated.[53] Access to dependent coverage is greater for fathers who have incomes at 200 percent of poverty or above; only one-third of these fathers do not have access.

Medicaid and Child Support Enforcement

As a condition of eligibility, individuals applying for medical assistance must cooperate with the State in establishing paternity and obtaining medical support and payments and in identifying and providing information to assist the State in pursuing third parties who may be liable for payment. In situations where a parent is filing for Medicaid on behalf of themselves and a child, it is a condition of the parent's eligibility that the parent cooperate in establishing paternity and obtaining medical support.[54] However, in cases where a parent (or legal guardian) is filing only on behalf of a child and not for him or herself, it is not a condition of the child's eligibility for the parent to cooperate.

There are two circumstances in which exceptions to the cooperation requirements may be made. A woman eligible for Medicaid under the poverty level pregnant woman category does not have to cooperate in establishing paternity and obtaining medical support payments from the father of an unborn child or a child born out of wedlock. In addition, if the State determines that an individual has good cause for refusing to provide the information sought, the applicant is not required to disclose the required information.

What is the State Children's Health Insurance Programs (SCHIP)?

Concerned that many low-income families did not qualify for Medicaid and could not afford private insurance, Congress established the State Children's Health Insurance Program (SCHIP) in 1997.[55] SCHIP is the single largest expansion of family health coverage for children since the enactment of Medicaid. This program allows States to provide free or affordable health care coverage to uninsured children in families whose incomes are too high to qualify for Medicaid but too low to afford private coverage.[56] SCHIP is not intended to replace private insurance but rather to serve as the provider of last resort, where private health care coverage is unaffordable or unavailable.

The Federal government provides matching funds for SCHIP programs, and States have flexibility to structure the program to meet local needs. A State can expand its coverage for uninsured, low-income children by using its Medicaid program to provide services to SCHIP-eligible children or establishing a separate child's health care coverage program, or do both.

SCHIPs, like Medicaid, are not fully utilized by all eligible children. However, State reported enrollment data for the Federal Fiscal Year 1999 show that SCHIP is making a significant contribution toward the goal of reducing the number of uninsured children in the United Sates. As of September 1999, nearly two million children were served by SCHIP: close to 700,000 children were served by State expansions of existing Medicaid programs and over 1.2 million children have been covered through separate SCHIP funded child health programs.[57] Enrollment remains a top priority. Almost 75 percent of the 3 million uninsured child support-eligible children have family incomes below 200 percent of poverty, making them potentially eligible for SCHIP or Medicaid.[58]

Eligibility

In general, children are eligible to participate in SCHIP if their family income exceeds the maximum limit for Medicaid coverage in their State, but is at or below 200 percent of the Federal poverty level. In some States, eligibility extends beyond this to 350 percent.[59] States can impose premiums or require co-payments and deductibles from parents of children in the SCHIP program, so long as the total amount required does not exceed five percent of the families' monthly gross income.[60]

However, the picture is much bleaker for fathers with incomes below 200 percent of poverty; almost three-fourths of these fathers have no access to dependent health care coverage. The study estimates that over four million noncustodial parents, three million low-income fathers, and one million fathers with incomes over 200 percent of poverty, have no access to employer-provided dependent coverage.[61] These fathers are likely to be the noncustodial parents of children enrolled in or eligible for Medicaid and SCHIP.

Assumptions for the New Medical Support Paradigm

When old assumptions do not fit the facts, new ones need to be formulated. Based on the extensive information the Working Group heard, read, and discussed, a set of new underlying assumptions about access to health care coverage emerged.

❶ New Assumption #1

Because both custodial and noncustodial parents are likely to be employed, both parents should be looked to for the possibility of private health care coverage. When both parents are considered, children have a better chance of getting private coverage.

❷ New Assumption #2

Lack of job stability affects a parent's ability to provide health care coverage. Pursuing private coverage from parents who have a history of frequent job changes can increase administrative costs for both IV-D agencies and employers without children being better off. Stability of employment should be a factor in considering whether to pursue private health care coverage.

❸ New Assumption #3

Dependent health care coverage is income-sensitive. Relative to income, it is much more expensive for low-and moderate-income parents to carry coverage than for middle- and upper-income families. Unless coverage is offered at no or very low cost, neither custodial nor noncustodial parents whose income is at or near the poverty line should be required to provide private health care coverage.

❹ New Assumption #4

Accessibility to coverage needs to be considered as part of the decisionmaking process. If children do not have geographic access to the dependent health care coverage available from their noncustodial parent, purchase of such coverage should not be required.

⑤ New Assumption #5

Not all child support-eligible children will have access to private family health coverage because many noncustodial parents have the same type of access limitations to private health care coverage as low- and moderate-income custodial parents. Private health care coverage should be pursued when it is available to determine if it could expand coverage options. But when private coverage is not available or appropriate, other means of coverage, such as Medicaid, SCHIP, or other group plans should be pursued.

A chart of the major components of the new paradigm that encompasses the recommendations of the Working Group is presented on the following page.

In the new medical support model, private health care coverage remains central and employers remain key stakeholders to accessing private health care coverage for children. The IV-D child support agencies and courts would consider health care coverage that is available to both the custodial parent and the noncustodial parent. The new model would consider the stability of parent's employment and family health coverage so that administrative efforts by all stakeholders would be commensurate with the gain in health care coverage for children. The new model also would look at the relationship between premium cost and gross income to determine if employment-based coverage is reasonable in cost.

Children's ability to actually receive services through private coverage would be an important consideration. Where private insurance is unavailable or unreasonable given the financial resources of the parents, State child support enforcement agencies would advise families that they may qualify for public health care coverage (or help them obtain such benefits). The lack of reciprocal referrals are a critical failing within the present system. Private health care coverage currently is sought when children are in publicly-funded health care programs, but when private health care coverage is not available, families are not usually informed about their children's eligibility for publicly-funded health care.

> *"Determine which parent has the better health plan, ... sign up the child for that health plan and then apportion costs according to the parent's ability to pay. If only one parent has a health plan, sign up the child for that health plan, and then apportion costs accordingly. If neither parent has a health plan, you might consider what we've learned California has....[a] new health plans just for kids.... If you don't find two parents with plans or even one parent with a plan, in California you can sign up your child in a low-cost plan."*
> **~David Levy, President, Children's Rights Council**

The Working Group's New Paradigm	
Increase the Number of Children in Single-Parent Households with Health Care Coverage	It is in the best interest of both children and the nation that the maximum number of children have access to health care coverage. Lack of such coverage affects children's current and future health and their ability to be productive citizens. Moreover, when lack of care leads to poor health, the short- and long-term costs to employers, insurers, and publicly-funded health programs such as Medicaid and Medicare increases.
Appropriate Private Dependent Health Care Coverage Comes First	Parents share primary responsibility for meeting their children's needs. When one or both parents can provide comprehensive, accessible, and affordable health care coverage that coverage should be provided to the child.
Look to Both Parents as a Source of Coverage	Coverage available to both parents should be considered in setting a medical support obligation. If only the custodial parent has coverage, that coverage should be ordered and the noncustodial parent should contribute toward the cost of such coverage. When both parents are potentially able to provide coverage, the coverage available through the custodial parent (with a contribution toward the cost by the noncustodial parent) should normally be preferred as it: 1) is most likely to be accessible to the child; 2) involves less difficulty in claims processing for the custodial parent, the provider, and the insurer; and 3) minimizes the enforcement difficulties of the child support agency or private attorney responsible for the case.
Affordable Coverage	In deciding whether to pursue private coverage, the cost of coverage should be considered. To the maximum extent possible, public dollars (through, for example, enrollment in Medicaid/SCHIPs) should be the payment of last resort. However, private insurance should not be ordered when its cost significantly lowers the amount of cash support available to meet the child's basic needs and the child is eligible for some other form of coverage.
Accessible Coverage	When private health care coverage is available to a child, the child support enforcement agency should consider the accessibility of covered services before it decides to pursue the coverage. Children should not be enrolled in any plan whose services/providers are not accessible to them, unless the plan can provide financial reimbursement for services rendered by alternate providers.
Seamless Coverage	The child support (IV-D) program should work in close conjunction with Medicaid/SCHIPs to ensure that children who have access to private coverage obtain such coverage, and those who are eligible for publicly-subsidized coverage are covered by Medicaid or SCHIPs.

Summary

Twenty-one million children will be affected by this new medical child support model. Once implemented, the new model will improve the ability of mothers and fathers to fulfill their shared responsibility of providing for their children's health care needs. It will assist private attorneys, courts, and the IV-D system to identify all coverage options and to enroll children in the most appropriate private or public health care coverage. The new model will also improve the efficiency with which the IV-D system, employers, and plan administrators can get children enrolled in private coverage to ensure that lapses in coverage are minimized. Lastly, the new model will provide for better coordination between the IV-D system and publicly-funded health programs, so that children without private coverage can be enrolled in Medicaid or SCHIP. The goal of the new model is clear: To increase private health care coverage and to reduce the number of children with no coverage without a significant increase in cost for parents, health services providers, employers, insurance companies, and the American taxpayer.

Endnotes

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[1] Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), Pub. L. 104-193 and the Child Support Performance and Incentive Act (CSPIA), Pub. L. 105-200.

[2] 45 CFR sections 302.80, 303.30 and 303.31 (1990).

[3] 42 U.S.C. §667(b) (1998). The State guideline applies to all orders for child support whether or not the custodial parent is receiving services under the IV-D Program.

[4] 45 CFR 303.30 and 303.3.

[5] 42 U.S.C. §652(f) (1999).

[6] 42 U.S.C. §666(a)(19) (1999).

[7] 29 U.S.C. §1169(a).

[8] 29 U.S.C. §1001 et. seq

[9] Pub. L. 105-33, §5611 and §5613. Note that recognition as a QMCSO requires that the order satisfies the requirements of §609(a).

[10] 29 U.S.C. §1169(a)(3).

[11] 29 U.S.C. §1169(a)(4).

[12] 42 U.S.C. §1396g(a)(1).

[13] 42 U.S.C. §1396g(a)(2) and (3).

[14] Pub.L.105-33.

[15] Pub.L. 99-272 (COBRA) and Pub.L. 104-191 (HIPAA). For full citations to these Acts, see U.S.C. Tables volumes.

[16] 29 U.S.C. §1002(16).

[17] The provisions of ERISA are located at 29 U.S.C. §1001 et. seq.; Title IV of the Social Security Act at 42 U.S.C. §601 et. seq.; Title XIX of the Social Security Act at 42 U.S.C. §1396 et. seq.; the Public Health Service Act at 42 U.S.C. §300 et. seq.; and the Internal Revenue Code at 26 U.S.C.

[18] Pub. L. 93-406, 88 Stat. 829, which generally appears as 29 U.S.C. 1001 et. seq. For full classification of this Act, consult U.S.C. Tables volumes.

[19] Pub. L. 99-272, 100 Stat. 327 at 4001.

[20] Pub. L. 104-191, 110 Stat. 1992, codified in various sections of the U.S. Code.

[21] Under Social Security Act, §466(a)(19).

[22] Under ERISA, §609(a).

[23] Scoon-Rogers, Lydia. "Child Support for Custodial Mothers and Fathers: 1995." *Census Bureau Current Population Reports* (March 1999), 60-196.

[24] The U.S. Census Bureau reports that 63.3 percent of all children were covered by employment-based health plans in 1998 (U.S. Department of Commerce, Bureau of the Census, Health Insurance Coverage: 1998, Table 6).

[25] Weinick, Robin and Alan C. Monheit. "Children's Health Insurance and Family Structure." *Medical Care Research and Review*, 56:1 (March 1999), 66.

[26] Weinick and Monheit, 66.

[27] Wheaton, Laura. "Noncustodial Fathers: To What Extent do They Have Access to Health

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Care Coverage?" The Urban Institute (2000), 27.

[28] Bureau of Labor Statistics, *Employee Tenure in* 1998. See http://www.bls.gov/news.release/tenure.nws.htm

[29] Gordon, Anne. *Income Withholding, Medical Support, and Services to Non-AFDC Cases after the Child Support Amendments of 1984*, Volume 1, Mathematica Policy Research, Inc. (1991). Under Contract with the Department of Health and Human Services/Office of Child Support Enforcement.

[30] Gordon (1991).

[31] Wheaton (2000), 39.

[32] See O'Brien, Ellen and Judith Feder. *Employment-Based Health Insurance Coverage and Its Decline: The Growing Plight of Low-Wage Workers.* The Kaiser Commission on Medicaid and the Uninsured (May 1999).

[33] United States Government Accounting Office, Report to Congressional Committees, Employment Based Health Insurance (July 1998), GAO/HEHS-98-184, Table 3. (Eligibility rate of part time employees was about 31 percent, in contrast to a rate of more than 80 percent for full-time workers in 1997.)

[34] United States Government Accounting Office, Report to Congressional Committees, Employment Based Health Insurance (July 1998), Table 2.

[35] O'Brien, Ellen and Judith Feder, *How Well Does the Employment-Based Health Insurance System Work for Low-Income Families?* Kaiser Commission on Medicaid and the Uninsured (September 1998), 4.

[36] O'Brien and Feder (1999), 5.

[37] Unpublished estimates by the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, using the 1997 Consumer Expenditure Survey.

[38] O'Brien and Feder (1998), 5.

[39] McNeil, John. *Changes in Median Household Income: 1969 to 1996.* U.S. Bureau of the Census (July 1998), 23-196, Table 5b. http://www.census.gove/hhes/incom/mednhld/t5b.html

[40] Lyon, Matthew. "Characteristics of Families Using Title IV-D Services in 1995." U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (May 1999), Table 1.

[41] Sorensen, Elaine and Laura Wheaton, *Income and Demographic Characteristics of Non-Resident Fathers in 1993*, The Urban Institute, (forthcoming June 2000). Prepared under contract with the Department of Health and Human Services, HHS 100-95-0021. Note that information on custodial parents from the Lyon analysis includes both custodial mothers and custodial fathers, while information on noncustodial parents from the Sorensen and Wheaton report is available for fathers only.

[42] U.S. Commission on Interstate Child Support, "Supporting Our Children: A Blueprint for Reform."

[43] See, for example, Lyon (1999), 4; U.S. Commission on Interstate Child Support, "Supporting Our Children: A Blueprint for Reform," xii; and Wheaton (2000), 19.

[44] Wheaton (2000), 15.

[45] HCFA, Office of the Actuary, President's FY 2001 Budget Baseline

[46] 1996 March-April Match File Current Population Survey. See data tabulations in APPENDIX D: Health Care Coverage for Child Support-Eligible Children, page A-32.

[47] 42 U.S.C. §1396a(10)(A)(i)(III) (1999).

[48] Annual update of the Department of Health and Human Services poverty guidelines for CY 2000–As published in the Federal Register, Vol. 65, No. 31, February 15, 2000, 7555-7557.

[49] They may cover children in families with incomes up to 185 percent of the poverty level for a family of three. 42 U.S.C. §§1396a; 1396r-6(b)(3)(B)(iii)(III) (1999). This level was $26,177.50 in 2000. Annual Update of the HHS Poverty Guidelines, published in the Federal Register 2/15/00.

[50] Levitt, Larry, Janet Lundy, and Srija Srinivasan. *Trends and Indicators in the Changing Health Care Marketplace Chartbook.* The Kaiser Family Foundations (August 1998), 18.

[51] Levitt, Lunday, and Srinivasan, 21.

[52] Wheaton (2000), 34.

[53] Wheaton (2000), 36.

[54] Section 1912(a)(1).

[55] 42 U.S.C. §1397aa et seq. (1999).

[56] 42 U.S.C. §1396aa (1999).

[57] U.S. Department of Health and Human Services, *State Children's Family health coverage Program Annual Enrollment Report (Fiscal Year 1999)* (January 2000).

[58] .1996 March-April Match File Current Population Survey. See data tabulations in APPENDIX D: Health Care Coverage for Child Support-Eligible Children, page A-32.

[59] New Jersey's separate SCHIP program includes eligibility up to 350 percent of the Federal poverty level. In Connecticut, Missouri,

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New Hampshire, Rhode Island, and Vermont SCHIP extends eligibility to 300 percent of the Federal poverty level.

[60] 42 U.S.C. §1397bb (1999).

[61] Wheaton (2000), 36.

CHAPTER 3.
Taking the First Step: Establishing Health Care Coverage in Child Support Orders

State Child Support Guidelines

As discussed in the introduction to this Report, the current medical child support model is based on a number of outdated assumptions. They include: (1) mothers are not in the paid labor force, (2) fathers are employed at the same job for most of their working lives, and (3) employers provide free or nearly free dependent health care coverage to their employees. Because presumptive State child support guidelines may be based upon these erroneous assumptions, they fail to maximize private family health coverage enrollment for children in single-parent households.

The first assumption, that mothers are not in the paid labor force, is clearly incorrect, as is testified to both by most people's experience

CHAPTER 3 AT A GLANCE

STATE CHILD SUPPORT GUIDELINES, 3-1
ROLE OF THE DECISION MAKER – ADMINISTRATIVE AGENCY, COURT, OTHER "TRIBUNAL," 3-4
  Coverage Options – Need for Information, 3-4
  Decisionmaking Principles, 3-6
  Children with Special Needs, 3-16
  The Decision "Matrix," 3-17
  Establishment of Orders for Publicly-Funded or Other Alternative Health Care Coverage, 3-22
    Public Payment for Private Coverage, 3-23
  Role of the IV-D Agency, 3-24
    Enrollment Authority, 3-25
  Contribution by the Noncustodial Parent, 3-26
  Birthing Costs, 3-29
  Apportioning Responsibility for Unreimbursed Health Care Expenses, 3-31
  Drafting the Medical Support Provisions of a Child Support Order, 3-34

Theme

The place to start reform is at the beginning, with order establishment. State child support guidelines are required to address how health care coverage will be provided, and it is important that each order include the health care coverage that is best for the child. The guidelines presented in this chapter lay out a matrix that directs the decision maker to consider the entire range of coverage options available to the child, including private coverage from either parent and, when appropriate, public coverage. In determining which coverage is best, the decision maker should consider not only availability, but other factors that influence the likelihood that the child will be appropriately and consistently insured, such as accessibility, comprehensiveness, and affordability. When the child is ordered into the appropriate coverage from the start, it will not only benefit the child, but will also reduce administrative and enforcement activity on the part of the IV-D agency, the insurer, and the parents.

as well as by government and academic studies. In the majority of households, both parents participate in the workforce. Thus, either parent may have access to employment-based family health care coverage.

In families with a formal child support order, 16 percent of these agreements order the custodial family to provide coverage and 37 percent order the noncustodial parent to provide it.[1] Among all custodial mother families, with or without a court order for support, 35 percent of the custodial parent families actually provide health care coverage for the child support-eligible children. The noncustodial parent, or someone else outside the household, provides health care coverage for 24 percent of these families.[2]

Yet the Working Group found that only 27 States' child support guidelines direct the decision maker to consider both parents as potential sources of health care coverage.[3] Within these States, recognizing the custodial parent's employer as a potential source of insurance has clearly paid off.

The remaining States' child support guidelines do *not* require consideration of coverage available to the custodial parent. In the worst case scenario in these States, children may not be enrolled in family health coverage at all. If no coverage is available through the noncustodial parent, and if the noncustodial parent has not been ordered to contribute to the cost of coverage under the custodial parent's plan, then the children may remain uncovered, as the cost of coverage is often prohibitive for the custodial parent alone. In other instances, the children in these States may indeed have family health coverage, but they may not be enrolled in the family health coverage plan that best meets their needs because the custodial parent's coverage has not been considered.

> *"[W] hat I want to press home is [that] the great [child support] legislation that's [been] enacted by the Congress of the United States just happens to [be]...best practices that have been tested, that have been validated, and that have been proven reliable by other states. So what about this—what some of you may think to be a revolutionary thought—involving custodial parents in medical support: we found that there are some 27 States that are enforcing medical support against both the biological parents."*
>
> **–Richard Harris, Director, Division of Child Support Enforcement, Mississippi**

For these reasons, the Working Group recommends amendment of Federal regulations to require States to revise their child support guidelines so that decision makers are required to explore health care coverage available to both parents.[4]

The Working Group also found that even when the State's child support guidelines direct the decision maker to look at coverage available to both parents, IV-D programs focus almost exclusively on the noncustodial parent. This is because Federal child support statutes and regulations assume that the noncustodial parent is the only possible source of coverage mandated, as well as because the historical mission of the IV-D program was to establish and enforce obligations against noncustodial parents.[5] Some States reported that they did not pursue custodial parent coverage because they believed it was not a proper IV-D program activity. This practice has to change in order to maximize the number of children who receive private coverage.

For this reason, the Working Group also recommends that Federal regulations at 45 CFR §303.31 be amended to make it clear that IV-D agencies can and should consider health care coverage available to either parent when they establish or modify a medical child support order. See Recommendation 1.

Ensuring that IV-D agencies consider health care coverage available to either parent when they establish or modify a medical child support award is, however, just a first step. It is also necessary to set clear guidelines regarding allocation of the costs between the parents. When the custodial parent provides and pays for the children's health care coverage, the noncustodial parent should share the cost of any required premiums. The child support order should require the noncustodial parent to do so, and the amount of the child support payment should increase accordingly. On the other hand, when the noncustodial parent provides and pays for the children's health care coverage, the cash support obligation may need to be adjusted (and in many cases already is) to reflect the cost of the coverage.

Towards this end, the Working Group recommends that child support guidelines include formulas for determining how the amount of the cash support award should increase or decrease in order to account for health care premiums, and child support orders should clearly specify how such amounts are to be allocated between the parents. Specifically, HHS should amend 45

Recommendation 1 (Federal Regulation)

The HHS should require each State to maximize the enrollment of children in appropriate health care coverage; the first recourse should be appropriate private coverage of either parent. *("Appropriate coverage" is defined in Recommendation 8.)*

CFR §302.56 to require that State child support guidelines include clear methods of adjusting child support awards to reflect the manner in which the parents will share the cost of premiums associated with the children's health care coverage.[6]

At this time, States use different approaches to allocate health care costs between the parents. Nineteen States and the District of Columbia[7] deduct the premium cost from the income of the parent who provides the coverage before calculating the amount of the child support obligation. Twenty- nine States[8] calculate the basic child support obligation and then they add some or all of the children's family health coverage cost to the support award if the custodial parent is providing coverage, or they deduct the amount from the child support obligation if the noncustodial parent is providing coverage. Two States[9] treat family health coverage costs as a reason to deviate from the presumptive amount determined under the child support guidelines.

Furthermore, the 29 States that allocate premium costs between the parents and add/subtract the amount from the basic cash award vary substantially in *how* costs are allocated. In four of these States, for example, the parent providing the coverage bears the entire cost.[10] In other States, the cost is split fifty-fifty.[11] In still others, the cost is prorated.[12] Where an allocation takes place, most States include only the marginal cost of covering the children, while the rest allocate the entire cost of family coverage.[13]

Clearly, there is currently no agreement between States as to a "best practice" regarding adjusting child support obligations to include health care premiums, so at this time the Working Group is not recommending a national standard for allocating premium costs. 📄 See Recommendation 2.

Role of the Decision Maker – Administrative Agency, Court, Other "Tribunal"

Coverage Options – Need for Information

The decision maker needs information about health care plans that are available to both parents in order to: (1) determine whether either has reasonable access to private health care coverage that is accessible to the child,

📄 **Recommendation 2 (Federal Regulation)**

Each State's child support guidelines should show how the cost of health care coverage will be allocated between the parents

(2) allocate costs, and (3) draft the medical support order. The parents themselves are the best source of this information.

Recognizing this, Alabama and New York enacted statutes that require both parents in all child support proceedings to provide information about any group health plans available to them.[14]

The Working Group recommends that HHS amend 45 CFR §303.31 to oblige all States to require each parent to disclose information about available private group health care coverage as a part of the State child support guidelines. See Recommendation 3.

Furthermore, while IV-D agencies currently have the authority to request information about health care coverage available or potentially available to a parent from employers,[15] many agencies are either not aware of this or they do not understand the potential value of gathering family health coverage information before a support order is established or modified.

Section 466(c) of the Social Security Act permits IV-D agencies to request information from employers and engage in individual case discovery. This will help States learn which employers offer dependent coverage to at least some of their employees and which do not. As State child support agencies obtain this information, they can begin (or continue) to build their own databases. They can supplement this information with data from other sources, such as Temporary Disability Insurance carriers or the Medicaid agency. States should be encouraged to do this so that they can begin to determine when they should request further information and when such a request would be futile. For example, if the State database shows that Corporation ABC does not provide dependent coverage to any of its employees, the IV-D agency would not request health care information from

Recommendation 3 (Federal Regulation)

Each State should develop mechanisms that require both parents to disclose information about actual and potential private health care coverage in order to help the decision maker determine whether private coverage is available to either parent.

Recommendation 4 (Federal Regulation)

States should use existing automated databases providing information about private health care coverage available through employers or use insurers' databases. Such databases need not contain information about the types of benefits offered, only whether dependent coverage is offered by an employer. For further details about the development of or modification to such databases, see Recommendation 64.

Corporation ABC. See Recommendation 4.

For this reason, in addition to recommending that States require parents to disclose family health coverage information, the Working Group also recommends that the Federal Office of Child Support Enforcement (OCSE) inform State child support agencies that they need to request health coverage information from employers. This disclosure of coverage information by employers and plan administrators is particularly important since many employers offer more than one plan to their employees,[16] and the decision maker must be familiar with all of the available options in order to determine the best health care choice for the children.

NMSN
National Medical Support Notice

In addition, DOL should make it clear to plan administrators that they must provide information on ERISA-covered health care plans when it is requested for the purpose of drafting a QMCSO, including completing a NMSN.[17] The Working Group suggests that DOL include this information in the booklet that is proposed in Recommendation 32. See Recommendation 5.

Decisionmaking Principles

There are three basic principles that should be considered when making decisions about coverage options for children's health care:

- Coverage should be comprehensive.
- Coverage should be accessible and stable.
- Coverage should be affordable.

Because continuity of care is very important, existing family health coverage should be maintained—regardless of which parent provides it—if it is comprehensive, affordable, and reasonably accessible. In Massachusetts, the law provides that if the custodial parent is currently providing coverage at a lower cost, or if the custodial parent prefers to maintain the coverage, irrespective of cost, the decision maker should not move the child to the noncustodial parent's coverage.[18]

The decision maker, however, should have

Recommendation 5 (Federal Guidance)

To further expand the ability of IV-D agencies to obtain information about actual and potential health care coverage available to both parents. OCSE should inform these agencies that §466(c)(1)(C) gives the agencies the authority to request health care benefits information from employers before they establish a medical support order. In conjunction with this, the DOL should inform plan administrators subject to ERISA that they must respond to such IV-D requests when they are made for the purpose of drafting a Qualified Medical Child Support Order (QMCSO). (See Recommendation 29.)

authority to order a change of coverage if that is in the best interest of the child. If, for example, the noncustodial parent has coverage that is accessible to the child and is available at no cost, while the custodial parent's coverage is very expensive, there is good reason to change. If the custodial parent's coverage is maintained, there will be less money available to meet the child's other basic needs. In such a case, then, the child would probably benefit from a change in coverage. See Recommendation 6.

Central to this decisionmaking process regarding the appropriateness of coverage is a determination of *comprehensive* coverage. States need to establish a definition of *comprehensive* coverage that will be used to evaluate insurance options.

Some plans are so limited, for example, that they do not meet the child's basic needs. Ordering such limited coverage may make the child ineligible for the State's CHIP, since SCHIP is limited to children with no coverage.[19] The Working Group determined that to be considered comprehensive, coverage must include at least medical and hospital coverage; provide for preventive, emergency, acute, and chronic care; and impose *reasonable* deductibles and co-payments. When comparing different plans to determine which is most comprehensive, the decision maker should consider basic dental coverage, orthodontics, eyeglasses, mental health services, and substance abuse treatment, and how such benefits meet each child's unique needs. When both parents have access to private coverage, an established definition of *comprehensive* coverage will provide States with a standard for determining which of the available plans is superior.

☞ See discussion of wrap around in CHAPTER 8, page 8-5.

In addition to ensuring that the most comprehensive coverage is ordered, decision makers must also ensure that the selected health care will be geographically *accessible* to the child—if it is not accessible, it is useless. Fee-for-service coverage is usually portable and does not raise access issues, but HMO and Preferred Provider Organization (PPO) coverage is frequently available only in limited geographic areas. Alternatively,

Recommendation 6 (Federal Legislation)

If the child is presently enrolled in either parent's private health care coverage and the coverage is accessible to the child, that coverage should be maintained. If, however, one of the parents has more appropriate coverage (as determined in accord with Recommendation 8 through Recommendation 11) and either parent requests that the child be enrolled in this plan, the decision maker shall determine whether or not to maintain the existing coverage based upon the best interests of the child.

reimbursement for the utilization of out-of-network providers may result in a lesser reimbursement payment and/or higher deductible and copayments. When the child lives in a different community from the parent who is ordered to provide coverage, the child may only be able to utilize the coverage for emergency services. These problems are minimal if the HMO has agreements with providers outside its service area. Such agreements allow the child to use alternate providers if the child lives outside its service area but in an area covered by one of these agreements.

However, in the absence of such agreements, serious problems arise. Children have theoretical coverage, but that coverage is useless because it is geographically inaccessible. Moreover, children may be in an even worse position than uninsured children—the "uninsured" children may be eligible for SCHIP, while these theoretically "insured" children are not.

A standard for determining geographic accessibility should be established so that access to a provider is not an unreasonable distance. The decision maker should determine if the primary care is available within 30 minutes or 30 miles of the child's residence. In lieu of a 30 minute/30 mile standard, an alternative standard may be adopted, such as those used by States that contract with a Medicaid managed care plan or that regulate managed care provider networks.

HCFA has issued guidance for organizations that contract with Medicare and Medicaid.[20] As a general rule, the primary care services and commonly used specialty and referral services are to be available within 30 minutes driving time from any point in the service area. Longer travel times may be permissible when residents in part or all of the service area customarily travel greater distances to obtain that service (e.g., in rural areas, or when there is only one provider of a given type in a broad region). Other factors to be considered are the means of transportation. In areas where low-income residents rely heavily on public transportation, the organization is to ensure that providers are accessible through these means.

Child support-eligible children face unique barriers in terms of access to health care coverage. One such barrier, as highlighted in Chapter 2 of this report, is that much of the health care coverage available to parents through their employers is provided through managed care organizations that limit the choice of service providers by geographic location or by a limited network of providers. If a noncustodial parent provides medical support through a restricted insurance plan, such as an HMO, available

☞ See "Prior Assumptions and Inadequate Solutions" in CHAPTER 2, page 2-9.

services may be inadequate when the covered child does not reside within or near the applicable service area (usually only emergency care is covered outside of the service area). The Working Group found that coordination agreements between plans that permit covered children to receive benefits outside the insurer's ordinary service area are a useful tool in expanding the health care coverage options that a decision maker may consider when establishing the medical support provisions of a child support order. Therefore, the Working Group recommends that the National Association of Insurance Commissioners (NAIC) encourage insurance providers to enter into coordination agreements. See Recommendation 7.

In addition to taking geographic accessibility factors into account, a determination of *accessibility* must also take into account the *stability* of coverage. Many parents have access to dependent health care coverage at the time an order is entered but lose coverage shortly thereafter. Similarly, parents with seasonal employment (such as summer camp staff), those whose hours of employment vary at different times of the year (such as construction workers and fishermen), and those who frequently change jobs can afford to help pay for family health coverage at some times of the year but not at others. The decision maker may thus order available coverage only to find that it is no longer available or affordable by the time the paperwork is completed. This is an exercise in futility and should be avoided when possible.

When determining *accessible* coverage, then, the decision maker should consider the likelihood that coverage will be stable for at least one year. In short, decision makers should not order private coverage when it will not be available for an extended period of time, or when it is geographically inaccessible to the child.[21] See Recommendation 8.

Recommendation 7 (Best Practice)

DOL and HHS should request the NAIC to encourage insurance providers with limited coverage areas to enter coordination agreements under which children who are covered under a geographically inaccessible plan can obtain services from a plan that is geographically accessible to them. Child support enforcement should publicize the availability of such plans and encourage States to take into account the possibility that out-of-area coverage may be available when assessing whether a particular plan is accessible to the child.

Decision makers must also address whether coverage is affordable. The definition of affordability must be considered in terms of *reasonable cost*. IV-D agencies are required to pursue private family health coverage whenever it is available at reasonable cost.

Recommendation 8 (Federal Regulation)

If a child is not enrolled in private coverage, the decision maker shall determine whether one or both parents are able to obtain *appropriate* coverage for the child based on three factors: (1) comprehensiveness of the plan, (2) access to services, and (3) affordability. Each factor should be assessed individually and then considered together in accord with Recommendation 13.

If a child has special needs, the decision maker should consider this circumstance in conjunction with the needs of the primary plan member and other dependents (see Recommendation 12).

Coverage is *comprehensive* if it includes at least medical and hospital coverage; provides for preventive, emergency, acute, and chronic care; and imposes reasonable deductibles and co-payments. In determining which coverage is more comprehensive when both parents have such coverage, the decision maker should consider the following: basic dental coverage, orthodontics, eyeglasses, mental health services, and substance abuse treatment.

Coverage is *accessible* if the covered children can obtain services from a plan provider with reasonable effort by the custodial parent. When the only health care option available through the noncustodial parent is a plan that limits service coverage to providers within a defined geographic area, the decision maker should determine whether the child lives within the plan's service area. If the child does not live within the plan's service area, the decision maker should determine whether the plan has a reciprocal agreement that permits the child to receive coverage at no greater cost than if the child resided in the plan's service area. The decision maker should also determine if primary care is available within the lesser of 30 minutes or 30 miles of the child's residence. If primary care services are not available within these constraints, the coverage should be deemed inaccessible. In lieu of the 30 miles/30 minutes standard, States may adopt an alternative standard for time and distance, such as the standard that the State uses to administer programs such as Medicaid managed care services or to regulate managed care provider networks.

In determining accessibility, the decision maker should also assess whether one can reasonably expect the coverage to remain effective for at least one year, based on the employment history of the parent who is to provide the coverage.

Reasonable cost should be assessed based on Recommendation 9 through Recommendation 11.

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Federal regulations state that "health insurance is considered reasonable in cost if it is employment-related or other group health insurance."[22] The definition deeming employment-related coverage to be *per se* reasonable in cost was first promulgated in 1985. It was justified by a 1983 study by the National Center for Health Services Research, which found that employers paid 72 percent of the premium cost for low-wage employees. OCSE thus concluded that "most employment-related or other group health insurance is inexpensive to the employee/absent parent."[23]

States have questioned the validity of this premise, however, since at least 1988.[24] And now, years later, there is even more reason to question the factual premise upon which this definition was based. The number of employers who offer completely subsidized dependent's coverage to their employees has significantly decreased.

GAO
General
Accounting Office

The GAO estimates that in 1980, 51 percent of employers who offered family coverage fully subsidized the cost, but by 1993, only 21 percent of employers fully subsidized the cost.[25] Recent research shows that low-wage workers, who are the primary constituency of the IV-D program, are concentrated in certain "low-wage" firms where employee contributions to the cost of the premium are higher than in other firms.[26] Furthermore, the required employee contribution for health care coverage represents a much larger share of family income for low-income workers.[27]

The size of the typical premium is not small.[28] The average percentage of the premium paid by the employee for family coverage ranges from 32 to 36 percent based on the plan type.[29] Employees at larger companies pay a considerably lesser percentage of their family health coverage premium costs than employees in smaller companies.[30]

Annual Premiums & Employee Contributions for Active Employees for Family Coverage, 1996*

Type of Plan	Average Premium	Average Employee Contribution
PPO (Preferred Provider Organization)	$5,377	$1,936
POS (Point-of-Service Plan)	$5,477	$1,862
HMO (Health Maintenance Organization)	$5,071	$1,673
Indemnity Plan/ Conventional Coverage	$5,388	$1,724

**Source: Employee Benefits Research Institute, EBRI Databook on Employee Benefits (1997).*

The estimates shown in the "Annual Premiums & Employee Contributions for Active Employees for Family Coverage, 1996" table suggest that on average, employee contributions to family health care coverage premiums are equal to 45 to 52 percent of the typical cash child support payment.[31] Since the cost of health insurance coverage can be such a large part of the child support order, requiring such coverage has implications for the amount of cash payments the child receives and the size of the noncustodial parent's obligation, depending on how a State takes the cost of health care coverage into account. A State may reduce the cash obligation by the amount of health insurance cost, adjust the calculation of the noncustodial parent's income based on health insurance costs, or simply add a health insurance requirement with no adjustment to cash award.

Clearly, employee contributions to insurance premiums impose a significant financial burden on the parent who is providing the dependent coverage. States have long recognized this in their State child support guidelines. Every State provides a mechanism to adjust the amount of the child support obligation when a parent provides health care coverage for his children.[32] If the custodial parent provides the coverage, the cash support award will probably increase, to reflect some contribution from the noncustodial parent toward the cost. If the noncustodial parent provides the coverage, the cash support award will probably decrease, to reflect the fact that that parent is subsidizing the cost of coverage through a separate deduction from wages toward the premium.

For more than a decade, States have worried about the effect of these adjustments in cash support, especially when the noncustodial parent is ordered to provide health care coverage.[33] If the premium associated with the coverage is too high, cash support will be substantially reduced, leaving the custodial parent without enough money to supply the child's basic needs. If cash support is not adjusted downward, however, poorer noncustodial parents will pay an unreasonably high portion of their income as support. If these parents cannot meet their own basic needs, they have little incentive to work and support their children, which may actually reduce the amount of child support they pay.[34]

Some States have addressed this problem by developing policies that look at the actual cost of providing insurance relative to the obligated parent's income. If cost exceeds a certain percentage of that parent's income, coverage is *not ordered.* For example, Washington State does not require the decision maker to order the noncustodial parent to pay coverage if the premiums are more than 25 percent of the noncustodial parent's basic child support obligation.[35] In other States, the decision maker exercises *discretion when the cost is too high*, even if the coverage is employment-related. For example, Colorado does not require the decision maker to order coverage if the premium exceeds 20 percent of the noncustodial parent's gross income.[36]

Other States compare the cost of family health coverage to the amount of the cash support award. For example, Maine does not require the decision maker to order coverage if the cost exceeds 15 percent of the parent's cash support obligation[37] and Montana has a similar rule if the cost exceeds 25 percent of the cash support obligation.[38] The Working Group also noted that the SCHIP program directs that contribution by the parent toward the cost of this health care coverage should not exceed five percent of a family's gross income.

The Working Group looked at these State policies in developing a new definition of *reasonable cost*. The Working Group began with the Maine/Montana approach, which calculates reasonable cost relative to the cash support award. The Working Group rejected this as a national guideline, however, because a significant number of States (12) use a child support guideline that calculates a cash support obligation only for the noncustodial parent. These States have no ability to calculate a support obligation for the custodial parent. If the custodial parent were to be the one ordered to provide coverage, there would be no way to adjust that parent's obligation in those States.

The Working Group also considered the amount of cash support owed under various State guidelines and concluded that using the Percentage of Support Obligation model would exacerbate existing inequities. There is enormous variation in different States' treatment of similarly-situated families. For a low-income family with a combined income of $14,400 per year, for example, the noncustodial parent's typical child support payment ranges from nothing in Connecticut to $327 in Indiana.[39] If the Federal government adopted a 25 percent of cash support standard, the Connecticut father would have no obligation, while the Indiana father would owe an additional $82, for a total obligation of $409. It is clear that this approach would compound existing inequities.

For this reason, the Working Group concluded that affordability should be determined with reference to the gross income of the parent providing the coverage. Even in States that use the Percentage of Income model, the gross income of both parents can be determined. Moreover, this approach does not exacerbate the inequalities that would be created if affordability were determined based on the Percentage of Support Obligation model.

The Working Group also debated the relative merits of the higher standard used by Washington and a percentage similar to that embodied in the SCHIP formula. The Working Group was concerned about the effects of reducing the amount of cash support when the noncustodial parent provides coverage, given the importance of maintaining sufficient cash support, especially at lower income ranges where large numbers of families are affected by welfare reform. Time limits and work requirements combine to move many families from public assistance to low-wage jobs and encourage others to avoid using the public assistance system. These families need cash support to meet their children's other essential needs.

In addition, the Working Group was concerned that a combination of cash support and a health care premium equal to 25 percent of the child support obligation could be high enough to send the obligation over Federal wage withholding limits. When this happens, employers are left trying to figure out what to do, IV-D agencies have to go back and modify orders, and children lose coverage. The Working Group selected a nonvariable percentage of income that applied throughout the country and, in most cases, that would keep the largest number of orders within withholding limits.[40]

Consequently, the Working Group concluded that the best approach was to use the five percent of gross income standard, which is based on the standard used in the SCHIP program. The Working Group was persuaded that the SCHIP standard struck a reasonable balance between cash and premium costs, was consistent with existing public policy, would minimize the number of cases where cash and medical support obligations exceed withholding limits, and would enable consistency in recommendations for cases where public, rather than private, coverage is used. For these reasons, the Working Group recommends that 45 CFR §303.31(a)(1) be amended to reflect this standard. See Recommendation 9.

The five percent standard will be appropriate in most cases. At the lowest income levels, however, the additional cost of health care coverage may make the financial burden on

Recommendation 9 (Federal Regulation)

The Federal regulation that deems all employment-related or group-based coverage to be reasonable in cost should be replaced with a standard based on the cost of coverage relative to the income of the parent who provides the coverage. Except as noted in Recommendation 10 and Recommendation 11, if the cost of providing private coverage does not exceed five percent of the gross income of the parent who provides coverage, then the cost should be deemed reasonable.

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the noncustodial parent too high. If that burden is adjusted downward, cash support may not significantly contribute toward the cost of providing basic necessities for the children. For this reason, States should not order noncustodial parents with incomes below 133 percent of the poverty level to provide private health care coverage to their dependents unless such coverage is available at no cost. See Recommendation 10.

The Working Group also recommends that OCSE identify this as a best practice and disseminate information regarding the rationale for it to the States. The preamble to the Federal regulations defining *reasonable cost* should also include this information, so that it will be clear to States that they have the flexibility to adopt this approach.

Similarly, if a custodial parent's income is so low that her resident child qualifies for or is receiving Medicaid, that parent should not be required to provide private coverage unless such coverage is available at no cost. The Working Group also recommends that OCSE identify this as a best practice and disseminate supporting information to States. The preamble to the Federal regulations should also state that deviation is allowable in extremely low-income cases. See Recommendation 11.

In sum, the Working Group recommends that there should be some minimum national standard for determining the appropriateness of coverage based on *comprehensibility, accessibility,* and *affordability*. HHS should include definitions/standards for these terms in a revised 45 CFR §303.31. Standard definitions will promote greater equity between similarly-situated families in both intra-state and interstate cases. The current lack of uniformity leads to situations where inappropriate coverage is ordered for one child but not for another, where some parents are paying for useless coverage while others are not, where some children

Recommendation 10 (Best Practice)

No parent whose net income is at or below 133 percent of the Federal poverty level should be ordered to provide private coverage, unless that parent has access to private coverage that does not require an employee contribution to obtain coverage.

Recommendation 11 (Best Practice)

No parent whose resident child is covered by Medicaid, based on that parent's income, should be ordered to provide private coverage, unless the parent has access to private coverage that does not require an employee contribution to obtain coverage.

receive less cash support because their parent is paying for inaccessible coverage but other children do not lose cash support for this reason, and/or where some children are denied SCHIP coverage because inaccessible coverage is theoretically available to them while other children enter the SCHIP program because the decision maker has recognized the futility of ordering inaccessible coverage. Overall, establishing standard definitions for *affordable, comprehensive,* and *accessible* coverage will maximize the number of children who are enrolled in stable, comprehensive, accessible, and affordable family health coverage.

Children with Special Needs

In determining the appropriate type of health care coverage for children with special health needs (CSHNs), it is of paramount importance to consider the medical, mental, and social service needs of these children and their guardians. CSHNs are at great risk of chronic illnesses and disabilities. Therefore, attention must be given to their routine preventive and acute care. Many of the services necessary to address these conditions may not be covered in certain health care plans, and it is essential that CSHNs have continuity of care.[41] In determining appropriate health care coverage for CSHNs, it is important for the decision maker to consider which plans are adequate to meet those needs. A common definition of CSHNs would help facilitate the decision maker's determination of the appropriate plan enrollment and system(s) of care, whether private, Medicaid, or SCHIP coverage. For some families, for example, health care coverage would outweigh cash support as the primary need. Flexibility must be available to the decision maker to accommodate such individual situations.

See Recommendation 12.

Recommendation 12 (Federal Guidance)

The decision maker must consider a child's special medical needs when deciding which form of private or public coverage is appropriate under Recommendation 8 through Recommendation 11. HHS should identify governmental agencies that are currently studying issues involving children with special needs and should coordinate with these agencies in the development of a common definition of "special needs" children. HHS should provide guidance to State IV-D agencies on how best to use the decisionmaking matrix set out in *Recommendation 13* when a special needs child is involved.

HCFA should require Medicaid agencies to identify whether there is a special needs child in any case they refer to the IV-D program pursuant to the child support cooperation requirement of the Medicaid program.

The Decision "Matrix"

Once the decision maker has obtained all of the pertinent information concerning the child's needs, health care plans available to both parents, and the parents' ability to pay, they must determine which of the parents is best able to provide comprehensive, stable, affordable, and accessible coverage that serves the best interests of the child. The table on the following page, "Decision Matrix for Tribunal Use," illustrates the decision logic for the tribunal to use in determining whether to order private or public group health care coverage.

Steps 1-3 reflect the basic principle articulated in Recommendation 3—that is, that the decision maker should first determine if either parent has accessible, affordable, comprehensive coverage. When it is clear that only one of the parents has access to comprehensive coverage, this coverage should be ordered.

Step 4 tells the decision maker what to do if only one parent has accessible, affordable, comprehensive coverage. If only the custodial parent has such coverage, then that coverage should be ordered. Likewise, if only the noncustodial parent has such coverage, then that coverage should be ordered. What the Working Group's decision matrix makes clear is that even if the custodial parent is the one with access to such coverage, that parent should be ordered to provide it.

Step 5 tells the decision maker what to do when both parents have access to comprehensive, accessible, and affordable coverage. In these situations, the Working Group recommends that the custodial parent's coverage should be ordered. We recommend this for a number of reasons.

- First, children will benefit. The custodial parent's coverage is more likely to be easily accessible to the child. As discussed earlier, if coverage is not accessible, it is not used.
- Second, using the custodial parent's coverage will most likely decrease the IV-D agencies' enforcement burden. Custodial parents have a strong incentive to enroll the child in available insurance: if they do not do so, they will be responsible for all of the bills. Accordingly, the custodial parent is likely to act more quickly and require less prodding by the IV-D agency. The custodial parent will know when a job change is imminent and when the children need to be moved to the new policy or, if the new job does not provide dependent benefits, when the medical support order needs to be modified. This will reduce the amount of time that elapses before the IV-D agency learns that the order needs modification.

DECISION MATRIX FOR TRIBUNAL USE

(To Determine Appropriate Coverage for a Child Not Currently Enrolled in Any Coverage)

Step	Situation		Action
1	**Is private coverage *available*?**		
	custodial parent: YES	noncustodial parent: YES	Go to Step 2
	custodial parent: NO	noncustodial parent: YES	Go to Step 2
	custodial parent: YES	noncustodial parent: NO	Go to Step 2
	custodial parent: NO	noncustodial parent: NO	Custodial parent enrolls in Medicaid/SCHIP, or other available coverage
2	**Does the child have *access* to coverage?**		
	custodial parent: YES	noncustodial parent: YES	Go to Step 3
	custodial parent: NO	noncustodial parent: YES	Go to Step 3
	custodial parent: YES	noncustodial parent: NO	Go to Step 3
	custodial parent: NO	noncustodial parent: NO	Custodial parent enrolls in Medicaid/SCHIP, or other available coverage
3	**Is *cost* reasonable?**		
	custodial parent: YES	noncustodial parent: YES	Go to Step 4
	custodial parent: NO	noncustodial parent: YES	Noncustodial parent
	custodial parent: YES	noncustodial parent: NO	Custodial parent enrolls
	custodial parent: NO	noncustodial parent: NO	Custodial parent enrolls in Medicaid/SCHIP, or other available coverage
4	**Does one parent have better coverage?**		
	YES: custodial parent's coverage is better		Custodial parent enrolls
	YES: noncustodial parent's coverage is better		Noncustodial parent enrolls
	NO: coverage is of equal quality		Custodial parent enrolls, unless a special determination is requested

- Third, using the custodial parent's own coverage is procedurally easier for parents, employers, insurers, and plan administrators. Employers and plan administrators routinely distribute information about coverage, provide claim forms to their employees, and acknowledge the employee's signature on claims. It is far more difficult for employers, insurers, and plan administrators to deal with the custodial parent when the noncustodial parent provides coverage. Thus, communication regarding the child's health insurance is eased considerably when the custodial parent is the policy holder. Moreover, the COBRA and HIPAA rules are very clear for dependents covered by the custodial parent, but less clear for dependents covered by the noncustodial parent.[42]

COBRA
Consolidated Omnibus Budget Reconciliation Act of 1985

HIPAA
Health Insurance Portability and Accountability Act of 1996

While there are many reasons for using the custodial parent's coverage when both parents have access to comprehensive, accessible, and affordable coverage, the Working Group recognizes that either parent may prefer the noncustodial parent's coverage in some instances. For example, if a child needs mental health services and the noncustodial parent's policy provides for such services while the custodial parent's policy does not, the former is obviously preferable. Or if the noncustodial parent is already providing dependent benefits to others in his household, and can add the child in question at little or no cost, it makes sense to use the noncustodial parent's policy.

The decision maker should have authority to assess what is in the child's best interest and order coverage accordingly. Consistent with Recommendation 1, this recommendation requires the decision maker to consider all sources of private coverage that may be available. This policy is also consistent with the direction States are now taking in this area. Of the 27 States whose child support guidelines require the decision maker to examine coverage available to both parents, six States require the decision maker to order the best and most affordable coverage.[43] One State, Arizona, actually provides a similar preference for custodial parent coverage[44] and Massachusetts expresses a preference for custodial parent coverage if it is already in place.[45]

Moreover, several IV-D program administrators expressed a desire to move in this direction but felt they did not have the authority to do so. This change should be embodied in a new Federal statute, so that IV-D agencies have clear authority to assess coverage available to both parents and order custodial parent coverage in appropriate situations. See Recommendation 13.

Recommendation 13 (Federal Legislation)

After determining that a child is not enrolled in private health care coverage, and that at least one parent could enroll the child in private coverage, the decision maker should determine which plan is most *appropriate* for the child (as defined in Recommendation 8) by evaluating the plan(s) in the following manner:

Step 1. Determine whether the child has access to the services provided under the coverage.

Step 2. Determine whether the cost of the coverage is reasonable.

Step 3. Determine whether the coverage is comprehensive.

Step 4. If, after following steps 1-3, the decision maker finds that only the *custodial* parent has accessible, affordable, and comprehensive coverage, that coverage should be ordered, with appropriate allocation of cost, as determined by the State child support guidelines. (See Recommendation 2)

If, after following steps 1-3, the decision maker finds that only the *noncustodial* parent has accessible, affordable, and comprehensive coverage, that coverage should be ordered, with appropriate allocation of cost, as determined by the State child support guidelines. (See Recommendation 2)

Step 5. If, after following steps 1-3, it is determined that accessible, affordable, comprehensive coverage is available to both parents, then coverage available to the custodial parent should be ordered unless (1) either parent expresses a preference for coverage available through the noncustodial parent; or (2) the noncustodial parent is already carrying dependent's coverage for other children, either under a child support order for those children or because the children reside in his current household, and the cost of contributing toward the premiums associated with the custodial parent's coverage is significant. If either of the exceptions applies, the decision maker should make an assessment of what is in the best interests of the child and order coverage accordingly.

If neither parent has family health coverage, see Recommendation 14 *and* Recommendation 15.

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Step-parents are another possible source of coverage. Census Bureau data indicates that approximately 17 percent of child support-eligible children live in step families.[46] Remarried custodial parents who do not have access to dependents health care coverage through their own employment may have access to such coverage through their new spouses. Decision makers should also be directed to explore coverage available through step-parents when it is appropriate to do so. Although it is not ideal to order a parent to secure health care coverage through a step-parent's plan, such plans should be taken into account when a medical support order is established or modified, when such coverage is available.

Step-parents traditionally have had no enforceable legal obligations to their step-children.[47] In States that continue this tradition, the step-parent's provision of health care coverage has always been purely voluntary because the IV-D agency or private attorney handling the case could not enforce the obligation. However, approximately 20 States have now created a statutory duty for step-parents to support their step-children, at least while they are married to the children's biological or adoptive parent.[48] In these States, step-parents may be compelled to provide private health care coverage to their step-children. If the new marriage does not last, however, the children will lose access to coverage. In such instances, the custodial parent will need to quickly seek a new order or learn about and exercise any COBRA rights that may exist.

> *"If you've gone through this process and you determine that both parents have accessible, affordable comprehensive coverage, then our preference at this point is to have the custodial parent provide the coverage for all the reasons that we've talked about in the past, in terms of that's the parent who most easily can enroll the child, who's got the forms, whose signature will be honored, who really takes away all the difficult enforcement issues from a IV-D perspective of having the noncustodial parent provide the coverage."*
>
> **~Paula Roberts, Senior Attorney, Center for Law and Social Policy**

In addition, not all employer-sponsored plans extend benefits to step-children. Employers who do not currently provide such coverage should not be forced to do so. Nevertheless, since some large employers, including the Federal government, do provide health care coverage to their employees' step-children, this option may be available and desirable. Every State should have some policy in this area. The policy should reflect the realities of the situation and consider step-parent coverage only when the parties themselves believe it is appropriate and employers ordinarily make such coverage available. Even then, the custodial parent should be warned to seek COBRA coverage or modification of the order if the marriage terminates. See Recommendation 14.

Establishment of Orders for Publicly-Funded or Other Alternative Health Care Coverage

In many cases, private health care coverage is simply not available to either parent.[49] In such cases, public or other alternative coverage must be considered, as the children—especially those in the IVD caseload—may be eligible for Medicaid or SCHIP benefits. In addition, some IVD agencies have worked with insurers to establish alternative lower-cost child-only plans that parents can purchase to provide coverage for their children.[50] These plans can be especially useful for children who do not qualify for Medicaid or SCHIP.

See the California IV-D Kids discussion in CHAPTER 8, page 8-7.

In other cases, private coverage is available but the cost is prohibitive. Medicaid, SCHIP, and alternative programs can also be helpful in these instances.

A few States have already taken the lead in granting decision makers the power to consider both public and private coverage when drafting or modifying support orders. For example, Connecticut's child support guidelines require the decision maker to order the custodial parent to apply for HUSKY B (the State's non-Medicaid SCHIP program) or an available equivalent

Recommendation 14 (Best Practice)

When neither parent has access to private health care coverage at reasonable cost but a step-parent does, enrolling the children in the step-parent's coverage should be considered *under certain conditions*. These conditions are: (a) the coverage is accessible to the children; (b) the step-parent is willing to provide such coverage; and (c) there are no employer/insurer constraints for enrollment of the child.

When these conditions are met, the parent who is married to the step-parent should be ordered to provide health care coverage for the children. The order should specify that this obligation may be met by enrolling the children in the step-parent's health care coverage. Moreover, the order must make it clear that if the obligated parent and the step-parent later commence proceedings for a separation or divorce, the obligated parent has responsibility for obtaining information about the cost and availability of COBRA coverage for the children and enrolling the children in this coverage. The order should also specify that if COBRA (or other) coverage is not available or affordable, the obligated parent must immediately seek modification of the medical provisions of the child support order. As an alternative, the custodial parent should seek publicly-funded coverage in order to minimize any lapse in coverage for the children.

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government-sponsored plan when private coverage is not available to either parent at reasonable cost.[51] Similarly, Texas requires the decision maker to order custodial parents to enroll in a program offered by the Texas Healthy Kids Corporation if private coverage is not available or affordable.[52]

All States should be encouraged to consider public or other alternative coverage when drafting or modifying support orders for children whose parents cannot provide private coverage. This approach could substantially increase the number of children with access to basic health care coverage.

Public Payment for Private Coverage

Children can also obtain private coverage with a public subsidy. State Medicaid agencies can use program funds to purchase group health coverage[53] if such coverage is available to a Medicaid-eligible individual. Alabama, for example, has been purchasing group health coverage for Medicaid beneficiaries since 1991. This is especially valuable to children living in areas with a limited number of Medicaid providers. Medicaid agencies also are permitted to pay for cost-effective group health premiums for certain individuals entitled to elect COBRA continuation coverage.[54]

SCHIP programs can also use program funds to subsidize coverage under employer-sponsored group health plans. If the coverage would also include individuals not eligible for SCHIP, the State would need to obtain a "family coverage waiver" from the Health Care Financing Administration (HCFA) in order to purchase the coverage.[55] Massachusetts and Wisconsin have elected to purchase family coverage through their SCHIP programs.[56]

> *"But there are lots of cases on the margin where there is very limited noncustodial parent income, where the source of private insurance is less clear. At that point ... enroll[ing] the child in CHIP or Medicaid ... maximizes benefits to everyone."*
>
> **~Nancy Ebb, Senior Attorney, Children's Defense Fund**

Essentially, employers and plan administrators are concerned that this ability on States' parts to subsidize private insurance may result in "adverse selection"—that is, the selection of children with serious, and costly, medical problems as those for whom it is deemed more cost-effective to pay the employee contribution for private coverage rather than enroll them in Medicaid or SCHIP.

For many self-insured plans, employee contributions represent only a small percentage of the plan's expenses, including benefit claims. In these plans, the employer is responsible for the majority of the plan's expenses. In addition, the group premium for insured plans is generally based on the nature of the risk pool of insureds, and again, the employer may be paying most of the premium. If there is a significant shift of high-risk/high-cost Medicaid and SCHIP-eligible children from those programs to group health plans (in other words, adverse selection), the cost to employers of maintaining these plans, whether self-insured or insured, may rise substantially. Thus selection criteria must be neutral and uniformly applied. An additional concern is that many (if not most) group health plans that require employee contributions are only equipped to receive such contributions through payroll withholding by and transmittal from the employer. Preliminary inquiries indicate that such plans are not administratively equipped to receive contributions from other sources, whether it be the employee or the Medicaid or SCHIP agency. Further analysis is needed to determine if the cost of modifying systems to permit such receipt would be substantial. The pros and cons need to be weighed in developing future policy. See Recommendation 15.

Role of the IV-D Agency

The five steps outlined earlier in Recommendation 13 for determining which plan is most appropriate for a child will not effectively ensure that children are enrolled in the best available coverage unless: (1) parents are aware of what public and private family health coverage programs are available, and (2) the child support agency helps them enroll their children.

Child support programs must conduct outreach activities to educate parents about government-sponsored family health coverage options. When SCHIP was enacted, OCSE's Deputy Director sent a letter to all State directors urging them to become involved in SCHIP implementation and outreach activities,[57] however only a few State child support programs have done so. This is partly because it was not clear whether such outreach activities were a IV-D function and therefore eligible for Federal Financial Participation (FFP). This funding issue needs to be addressed by including Medicaid/SCHIP outreach activities in Title IV-D. Unless this change

Recommendation 15 (Best Practice)

When neither parent can provide comprehensive, accessible, affordable private health care coverage, the decision maker should explore the possibility of providing coverage to the child through Medicaid or the SCHIP. If the child is ineligible for Medicaid or SCHIP, the decision maker should explore whether there is any available lower-cost, child-only plan, such as Sacramento IV-D Kids.

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in the program responsibility and funding can be resolved administratively, or by regulation, Congress should enact legislation that mandates this outreach role for State child support enforcement agencies. See Recommendation 16.

Enrollment Authority

Encouraging and enabling outreach activities, however, is just a first step for the IV-D agency. While the SCHIP statute does not expressly prohibit IVD agencies from enrolling eligible children in the program, IVD agencies are not permitted to enroll children in Medicaid. This must be changed. IVD agencies should be authorized to enroll children in Medicaid.

Section 1920A(b)(3)(A)(i)(I) of the Social Security Act, as added by §4912(a) of the Balanced Budget Act of 1997 (Pub. L. 105-33) added a new §1920A to the Medicaid statute.[58] The new law allows a "qualified entity" to determine a child's eligibility for Medicaid for a "presumptive eligibility period" on the basis of preliminary information that the family income of the child does not exceed the State's Medicaid income eligibility level. The presumptive eligibility period is the month in which the presumptive eligibility determination is made plus the next month, a period of approximately 28 to 62 days; it terminates when the Medicaid agency determines "regular" eligibility. "Qualified entities" currently include Medicaid providers as well as agencies that determine eligibility for the Head Start, Child Care, Development Block Grant, and Women Infants and Children (WIC) programs.

The Working Group is therefore recommending that IVD agencies be added to the list of agencies authorized to determine presumptive eligibility and the Medicaid statute be amended accordingly. This would expedite enrollment of eligible children in the Medicaid program when private coverage is not an option.[59] The IV-D agency could use the income information obtained to calculate cash support under the guidelines to make a preliminary determination regarding a child's eligibility for Medicaid. The child could then be enrolled as presumptively eligible and coverage would begin

Recommendation 16 (Federal Legislation)

To facilitate enrollment of eligible children in public coverage, Federal law should require State IV-D agencies to: (1) provide parents with information about the Medicaid and SCHIP programs, as well as any other subsidized coverage that may be available to the child; and (2) refer the family to the appropriate program for possible enrollment.

immediately. See Recommendation 17.

While States should not be required to use their IV-D programs to make presumptive Medicaid eligibility determinations, they should be strongly encouraged to do so. If they choose not to, States should adopt other methods for facilitating the enrollment of eligible children in the Medicaid and SCHIP programs. See Recommendation 18.

Contribution by the Noncustodial Parent

When they are financially able to do so, both parents should contribute to the cost of their children's health care coverage. While the definition of *reasonable cost* proposed earlier precludes parents with access to employer-based coverage from being ordered to provide coverage if the cost is not *reasonable*, this does not preclude the parent from contributing *something* toward the cost of the child's coverage. In other words, while it may be unreasonable to expect the parent to pay the full premium for available private coverage in some cases, it is not unreasonable to expect the parent to contribute something towards public coverage.

If private coverage is not ordered, children are likely to enter the Medicaid or SCHIP program at substantial public cost. While Medicaid is an open-ended program, the SCHIP program has a specific appropriation. If all of the SCHIP funds are used up, otherwise eligible children have to be turned away. While this has not yet happened, the potential exists, particularly if current SCHIP outreach efforts are successful. Parents of SCHIP-eligible children who could help contribute toward the SCHIP costs should be asked to do so in order to preserve funds for other eligible children in the future. In addition, when children do enter Medicaid or SCHIP, the custodial parent may have to pay premiums, co-

Recommendation 17 (Federal Legislation)

Congress should amend §1920A of the Social Security Act to include IV-D agencies among the "qualified entities" that may enroll children in Medicaid for a presumptive eligibility period, based on preliminary information that indicates that the child is income-eligible for Medicaid

Recommendation 18 (Federal Guidance)

Provided that Congress amends the Social Security Act to allow State IV-D agencies to presumptively enroll children in Medicaid, OCSE and HCFA should strongly encourage all States to exercise this option or to take other steps to facilitate Medicaid enrollment, including placing Medicaid or SCHIP staff in IV-D offices, providing application forms to potentially eligible families, and arranging eligibility appointments.

payments, and/or deductibles. It is unfair not to ask noncustodial parents to contribute as well toward their children's health care costs in appropriate situations.

In order to achieve equity between custodial and noncustodial parents whose children are enrolled in Medicaid or SCHIP, the Working Group used the basic Medicaid and SCHIP cost-sharing policies as the starting point for its recommendation.

The Medicaid program is available to children in low-income families. Because these families are, by definition, low income, States are not allowed to charge custodial parents enrollment fees, premiums, deductibles, coinsurance, co-payments, or similar charges for most Medicaid services to children. However, the Working Group recommends that the same standard should also apply to low-income noncustodial parents. No cost-sharing should be imposed upon noncustodial parents with incomes below 133 percent of poverty, which is the cut-off for Medicaid eligibility.

Using this approach has three advantages: (1) the amount of cash support available to the child will not be diminished by virtue of the noncustodial parent's contribution to medical support; (2) the noncustodial parent's contribution to the child's support will likely remain below Federal wage-withholding limits, reducing the number of situations in which employers and IV-D agencies have to wrestle with that difficult issue; and, (3) obligations imposed on low-income noncustodial parents will not leave them with too little income to meet their own basic needs.

> *"-- noncustodial parents vary by age, income, and marital status, and I would hope, as we proceed with our work, that we would consider the sets of issues that really challenge under-employed and unemployed noncustodial fathers and mothers."*
>
> **~Jeffery Johnson, President and CEO, National Center for Nonprofit Planning and Community Leadership (NPCL)**

The SCHIP program is generally available to children with family incomes above the Medicaid level but below roughly 200 percent of poverty.[60] (At least eight States provide eligibility for children whose family income is above this level.[61]) Whether or not there is any cost sharing for services to SCHIP children depends on how the State chooses to implement its SCHIP program.[62] If a State implements SCHIP through Medicaid expansion, then the Medicaid rules apply and families cannot be charged for children's services. If a State creates a *separate* SCHIP program for some or all SCHIP-eligible individuals, then the State can require custodial parents to contribute toward the premium for those children covered by the separate program.[63] There are, however, limits on the amount that States can charge. *For families with income below 150 percent of poverty*, premiums can range from $1.00 per month to $19.00 per month, depending on family size and income.[64] *For families with incomes above 150 percent of poverty,* there are no specific restrictions on the amount that can be charged for premiums or deductibles/co-payments. The aggregate cost of all premiums, deductibles, co-payments, and co-insurance charges, however, cannot exceed five percent of the family's gross income. When charges exceed this amount, the State must suspend further charges.[65]

In short, in a separate SCHIP program States can impose costs on custodial parents with incomes above 150 percent of poverty as long as they stay within the five percent of gross income ceiling. It is appropriate to establish a similar cost-sharing scheme for *noncustodial parents* who are able to pay the costs. Therefore, the Working Group's recommendation incorporates the five percent ceiling. This also harmonizes with the standard for determining the reasonable cost of private coverage. Coordinating the noncustodial parent contribution with that established for the custodial parent by Medicaid and SCHIP provides a coherent approach for decision makers to use to determine whether private or public coverage is appropriate.

As long as a parent is not required to contribute more than five percent of the family's gross income, States should be able to ask for premium contributions up to the actual premium cost. Or, if they wish, States may develop a sliding scale contribution schedule for noncustodial

Recommendation 19 (Best Practice, Federal Legislation)

Part A (Best Practice): States should grant authority to the decision maker to order the noncustodial parent to contribute toward the State cost of providing coverage under Medicaid and SCHIP. Provided, however, no contribution should be ordered from any noncustodial parent whose net income (as defined by the State to determine Medicaid eligibility) is less than 133 percent of poverty.

Part B (Federal Legislation): Congress should amend §467 of the Social Security Act to provide that the amount the noncustodial parent may be ordered to contribute toward the monthly cost of coverage under Medicaid or SCHIP shall be the *lesser* of: (1) the estimated cost of enrolling the child in Medicaid or SCHIP; (2) five percent of the noncustodial parent's gross income; or (3) the amount indicated by a sliding fee schedule, developed by the State, which takes into account ability to pay and average Medicaid/SCHIP costs for dependent children.

parents, similar to the ones many States use to impose premiums on custodial parents. In any case, both parents will then be contributing toward the cost of their child's coverage. See Recommendation 19.

Birthing Costs

Additional costs to be considered include costs associated with pregnancy and childbirth. Most States permit a mother to recover costs associated with pregnancy and childbirth from the alleged father when paternity is established.[66] This allows mothers who have paid these costs themselves to receive some reimbursement from the father. These laws are reasonable and should be maintained.

Applying these laws in cases where pregnancy and childbirth costs have been covered by Medicaid, however, is highly problematic. This is because it runs counter to two other important public policy goals: (1) encouraging mothers to seek prenatal care, and (2) encouraging fathers to establish paternity.

In 1985, the National Academy of Science's Institute of Medicine issued a report entitled *Preventing Low Birth Weight.* The report found that significant numbers of low-income women who were at high risk of giving birth to physically impaired infants did not seek prenatal care. As a result, many children were born with severe health problems. This was tragic for the children, and also meant that the public incurred substantial costs to care for these children. Better prenatal care would reduce these costs and give children a better chance for a healthy life.[67] This is a benefit for the private insurance industry as well.

That same year, the Southern Governor's Regional Task Force on Infant Mortality published a report that reached similar conclusions.[68] Both this report and the *Preventing Low Birth Weight* report identified the cost of care faced by uninsured mothers as a barrier to obtaining prenatal care and advised the government to expand Medicaid eligibility to deal with this problem. At the same time, these reports identified the child support cooperation requirement as a barrier within the Medicaid program itself. Some women who were eligible for Medicaid did not apply because they did not wish to establish paternity or seek medical support.

Congress responded by expanding and simplifying Medicaid coverage for pregnant women in what is called the Poverty Level Pregnant Women Program (PLPW Program). In 1990, Congress eliminated the child support cooperation requirement for participants in the PLPW Program.[69] In doing so, Congress observed that applying the cooperation requirement to pregnant women had discouraged many of the women from seeking benefits that would give them access to early prenatal care. Indeed, the support cooperation requirements were deemed "a potential barrier to prenatal care for high-risk, low income women that would most benefit from it."[70]

Congress recognized that eliminating the cooperation requirement would have fiscal consequences. States would no longer be able to seek reimbursement for prenatal, birthing, and post-natal Medicaid costs from the fathers of these children. Congress believed that the potential savings in human and fiscal terms, however, far outweighed the potential revenue loss. Thus Congress essentially adopted, a decade ago, a clear public policy that recognized that the value of encouraging mothers to seek and receive prenatal care far outweighed the potential cost recoupment from non-marital fathers.

Despite this clear public policy, some State child support enforcement agencies continue to pursue prenatal, birthing, and post-natal costs *after the child is born*. For example, if a mother receives TANF benefits, the State may bring a legal action seeking to establish paternity and a child support order seeking to recoup the birth-related costs. Courts have found this practice acceptable as long as the action is brought after the child's birth.[71]

TANF
Temporary
Assistance for
Needy Families

While this practice may be technically legal, it clearly runs counter to the intent of Congress in removing the child support cooperation requirement from the PLPW program. Furthermore, there is some evidence that this practice is once again causing mothers to forgo prenatal care. From the mother's point of view, it is irrelevant when the State pursues support. If there is a concern about cooperation, that concern will be just as real after the birth as before it.

For this reason alone, the Working Group believes that State IV-D agencies should not pursue pregnancy and birth-related costs in Medicaid cases.

Another reason to end this practice is that it discourages voluntary paternity establishment. Often the mother and father have an ongoing relationship and want to establish their child's paternity. Since the early 1990s, Congress has placed great emphasis on the value of encouraging voluntary acknowledgement. Federal law requires every State to establish laws facilitating the voluntary establishment of paternity through the use of a simple acknowledgment process available to the parents at the time of their child's birth.[72] Congress has provided incentive payments to States to encourage improvement in paternity establishment rates[73] and penalties for States that do not show improvement in this area.[74] The results are encouraging, but there is still more to be done, especially in working with low-income fathers.

If fathers acquire unrealistically high child support debt when they acknowledge paternity, they will neither admit paternity nor join these programs. Even an uncomplicated birth is expensive and a C-section can easily double the cost. Nevada reports that it seeks $3,100 for a normal delivery and $6,700 for a C-section in its Medicaid recoupment efforts. Projects that work with low-income fathers report that imposing responsibility for birthing costs of this magnitude makes fathers very reluctant to establish paternity and join the programs.

It is more important to establish paternity and future child support and to encourage fathers to establish a relationship with their children—perhaps through joining a fatherhood program—than to recoup pregnancy-related Medicaid costs. This is another reason why the Working Group believes that State child support enforcement agencies should not seek reimbursement of Medicaid-covered birthing costs.

Furthermore, since the fathers of children receiving Medicaid are likely to be low income,[75] the State usually cannot collect the assessed amounts anyway. Birthing costs thus artificially inflate the amount of arrears carried on the State's books and thereby make program performance appear worse than it is. Moreover, to the extent that the State does collect the medical expenses as arrears owed to the State, this money reimburses the State at the expense of additional support that might go to the child. When both parents have limited income, as is almost always the case when Medicaid is involved, the IV-D program should maximize the amount of support going to the child rather than collect State debt.

See Recommendation 20.

Apportioning Responsibility for Unreimbursed Health Care Expenses

Rarely are all health-related costs covered by family health coverage. Frequently, major expenses such as orthodontia, mental health services, and alcohol/drug rehabilitation are not covered at all. Unless these costs are addressed in the support order, the custodial parent has to absorb all of these costs. This inequity needs to be addressed.

Recommendation 20 (Federal Legislation)

Congress should amend Title IV-D of the Social Security Act to preclude State IV-D agencies from attempting to recover Medicaid-covered prenatal, birthing, and perinatal expenses from the noncustodial parent.

Ordinary expenses (band-aids, aspirin, etc.) are relatively trivial and allowance for them is built into most State's basic cash support guidelines amount.[76] Extraordinary expenses are usually treated as an add-on to the basic support obligation or as a factor to be considered in deviating from the guidelines. The big issue here is distinguishing "ordinary" from "extraordinary" expenses. Most States do not define the difference in their guidelines. This leaves it to the courts/administrative agencies to decide on a case-by-case basis what to do. Not surprisingly, there is a huge amount of litigation in this area.

Those States that do define the difference in their guidelines do so by looking at costs either by year or by illness. If unreimbursed expenses exceed a certain amount per year (e.g., they are greater than $250 per year per child) or they exceed a certain amount (e.g., $100) per illness, they can be considered "extraordinary." Seven States use the former approach (three with lower dollar limits) and five States use the latter.[77]

The Working Group believes that HHS should require every State to have a well-defined written policy defining extraordinary expenses. In addition, HHS should clarify that every State's child support guideline should give the decision maker the authority to order parents to share in the cost of co-payments, deductibles, and extraordinary expenses and should include such provisions in the support order.

See Recommendation 21.

Once it has been determined that a child has incurred an "extraordinary" expense, the cost must be apportioned between the parties. The Working Group learned that 23 States have a formula for allocating the costs, 24 States treat the existence of such costs as reason for deviating from the guidelines, one State issues separate orders for such costs, and three States do not address the issue. Of those with a formula, the majority prorate the costs between the parents.[78]

The Working Group believes that it would be useful to have a standard national methodology for dealing with these costs. This would create more equity between similarly situated parents. It would also make it easier for State IV-D agencies to handle the issue in interstate cases as the

Recommendation 21 (Federal Regulation)

The States should give the decision maker authority to order either or both parents to contribute toward (1) the cost of any co-payments, deductibles, or costs associated with the ordered health care coverage; and (2) any uncovered medical expenses incurred by the child.

standard for these cases would then be the same as the standard for in-State cases. Since a majority of States now use the proration method, the Working Group recommends that HHS require all states to adopt the add-on approach and pro-rate the expenses between the parents. See Recommendation 22.

Once "extraordinary expenses" are defined and the proration formula is established, it should be relatively easy for the parents to resolve payment of these expenses themselves. However, there may be disputes that have to be settled. One parent may question whether a particular expense was necessary. Another parent might question whether it was appropriate to use a particular provider whose fees are high. It is also possible that the services were provided by an entity that does not participate in the insurance plan and the other parent questions whether he should have to pay in those circumstances.

Settling these types of case-by-case problems is very labor intensive for private attorneys and can be very costly for the parents. Involvement in these individual case problems is usually not a good use of scarce IV-D resources. Several State IV-D programs reported that while they do get involved in such disputes, they consider them outside the basic mission of the IV-D program and a real drain in terms of time and personnel.

The Working Group felt that States would be wise to develop simple pro-se processes for parents to deal with these issues on their own. California, for example, has devised rules that require parents to share any bills they want to claim as extraordinary expenses within 30 days of receipt. If the provider is an entity that does not participate in the child's health care coverage program (for example, if the child is treated outside of his

Recommendation 22 (Federal Regulation)

To the extent that unreimbursed costs are not included in the State's basic child support guideline formula, those costs should be apportioned *pro rata* between the parties.

Recommendation 23 (Best Practice)

Since the extent of unreimbursed costs is unknown at the time an order is established, each State should develop protocols that permit the court or administrative agency to reduce such expenses to a judgment based on the language of the order. These protocols should include time limits for the parent who has paid the expenses to claim reimbursement and time limits for the obligated parent to pay these expenses, as well as simple pro se procedures for making or contesting such claims. The protocols should also include procedures to enforce collection from the noncustodial parent

HMO network), the use of that provider must be justified. See Recommendation 23.

Drafting the Medical Support Provisions of a Child Support Order

Medical support provisions in child support orders should be specific enough to identify exactly what health care coverage has been ordered, but general enough that health care coverage can be changed without modifying the underlying order. Although not necessary to make a medical support order qualified under §609(a) of ERISA, it would be helpful if the support order specifies how premium costs, deductibles, co-payments, and uninsured medical expenses will be shared between the parents. Not including

Recommendation 24 (Best Practice)

State child support guidelines should require that the medical support provisions of a child support order for private or public health care coverage clearly explain the obligation of each parent in meeting the child's health care needs. Although not necessary to be qualified under §609(a) of ERISA, orders should address, as fully as possible, each of the following issues:

- The party (custodial or noncustodial parent) responsible for obtaining public or private health care coverage
- The type of coverage to be obtained
- The cost of premiums and the manner in which each parent will contribute to those premiums
- The type of uncovered expenses for which the parties will share costs
- The specific manner in which each parent will contribute to the cost of uncovered expenses
- The designation of primary and secondary coverage in any case in which both parties are to provide health care coverage
- The circumstances under which the obligation to provide health care coverage for the child will shift from one parent to the other

Recommendation 25 (Federal Guidance)

To facilitate implementation of Recommendation 24, the DOL and HHS should develop model language regarding health care coverage for inclusion in child support orders. The model language, which would not be mandatory, would alert attorneys, child support workers, and court personnel to common issues that should be addressed in such orders.

Recommendation 26 (Technical Assistance)

Following adoption of the recommendations of the Medical Child Support Working group, DOL and HHS should provide training and technical assistance to courts to facilitate implementation of the recommendations, particularly those relating to the decision-making matrix and enrolling children in Medicaid and SCHIP.

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sufficient detail in medical support provisions may preclude employers and parents from: (1) identifying exactly what health care coverage has been ordered, (2) obtaining contribution toward uncovered expenses; and (3) obtaining reimbursement from any health care provider because of confusion over which coverage is primary and which is secondary.

Crafting a medical support provision in a child support order thus involves balancing all of these concerns. Every State should try to determine the proper balance, given its particular laws. The order should be as clear and concise as possible. 📄 See Recommendation 24, Recommendation 25.

The Working Group expects HHS and DOL to undertake substantial education and training efforts for IV-D, Medicaid, and SCHIP staffs. However, courts also play an important role in establishing and enforcing medical support. They should receive special attention from HHS and DOL, which should consult with judicial leaders, and the organizations that represent them, and collaborate with these organizations to train judges, court administrators, and clerks. 📄 See Recommendation 26.

Endnotes

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[1] Wheaton, Laura. "Noncustodial Fathers: To What Extent do They Have Access to Health Insurance?" The Urban Institute (2000), Table 2.

[2] Wheaton (2000), Table 3.

[3] This includes Alaska, Arizona, Colorado, Connecticut, California, Idaho, Indiana, Iowa Kentucky, Louisiana, Massachusetts, Michigan, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, North Dakota, Ohio, Oklahoma, Oregon, South Dakota, South Carolina, Tennessee, Texas, and Wyoming.

[4] See 45 CFR §302.56.

[5] 42 U.S.C. §652(f) (1999); 45 C.F.R. §303.31 (1999).

[6] It is worth noting that this recommendation echoes one made several years ago by the U.S. Commission on Interstate Child Support in its Report to Congress. The Commission recommended Federal regulations be changed to reflect "the payment of premiums for insurance plans carried by the custodial parent when such plans include the children at a cost less than that available to the obligor. This recognizes the realities of the health insurance marketplace, where the custodial parent may be able to obtain more comprehensive or less expensive coverage that that obtainable by the noncustodial parent." U.S. Commission on Interstate Child Support, "Supporting Our Children: A Blueprint for Reform," 138.

[7] Arkansas, California, Delaware, District of Columbia, Hawaii, Illinois, Iowa, Kentucky, Maine, Maryland, Michigan, Minnesota, Nebraska, New Hampshire, New Jersey, North Dakota, Rhode Island, Vermont, West Virginia, and Wyoming. Laura Morgan, Child Support Guidelines: Interpretation and Application, Table 3-1, §3.01a (1999).

[8] Alabama, Alaska, Arizona, Colorado, Connecticut, Florida, Idaho, Indiana, Kansas, Louisiana, Massachusetts, Mississippi, Missouri, Montana, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington and Wisconsin, *Id.*

[9] Georgia and Nevada, *Id.*

[10] Mississippi, Tennessee, Texas and Wisconsin.

[11] For example, Alaska, and Massachusetts.

[12] For example, Idaho.

[13] For example, Alaska, like the overwhelming majority of states, allocates costs based on the premium associated with covering the children in question, A.R.C.P. 90.3 (1999) (Morgan, Child Support Guidelines, §301(a) (1999)), while Massachusetts allocates based on the cost of family coverage (Mass. Gen. Laws Ann. Child Support Guidelines, II-G (1999)).

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[14] New York Family Court Act §424-a(a) reads in part: In addition, both parties shall provide information relating to any and all group health plans available to them for the provision of care or other medical benefits by insurance or otherwise for the benefit of the child or children for whom support is sought, including all information as may be required to be included in a qualified medical child support order."

[15] 42 USC §666(c) (1999).

[16] In 1998, of those employers offering health care coverage, 44 percent offered one plan, 24 percent offer two plans, and 32 percent provide three or more options (KPMG, *Health Benefits in 1988*, 30).

[17] Congress conditioned an alternate recipient's right to the receipt of benefits from a participant's group health plan on the condition that the alternate recipient obtain a medical child support order that satisfies specific information and other requirements. The DOL has expressed the view, in a similar circumstance regarding qualified domestic relations orders under §206(d)(3) of ERISA, that administrators of pension plans should provide to prospective alternate payees plan and participant benefit information sufficient to prepare a QDRO. Such information might include the summary plan description and relevant plan documents. See, *QDROs: The Division of Pensions Through Qualified Domestic Relations Orders*, Question and Answer 2-1, U.S. Department of Labor (1997), 12. It is reasonable to assume that similar standards would apply in the case of qualified medical child supp[illegible]ders.

[18] Mass. Ann. Laws, Child Support Guidelines, II-G (1999).

[19] 42 U.S.C. §§1397aa(a), 1397bb(b)(3)(C) (1999).

[20] HCFA issued interim standards on September 28, 1998, "Quality Improvement System for Managed Care," 61.

[21] As discussed in detail below, we anticipate that in such situations, the child would be enrolled in Medicaid or CHIP or another subsidized option if one is available (e.g., the Sacramento IV-D KIDS program) with financial contribution from the noncustodial parent commensurate with ability to pay.

[22] See, 45 C.F.R. §303.31(1999). The definition deeming employment-related coverage to be *per se* reasonable in cost was first promulgated in 1985. As early as 1988, States were questioning whether this was a viable definition. In response, Child Support Enforcement reiterated its assumption that "most employment-related or other group health insurance is inexpensive to the employee/absent parent" citing a 1983 study by the National Center for Health Services Research which indicated that for low-wage employees with access to employment-related health insurance, 72 percent of the premium costs were paid for by employers. 53 *Fed. Reg.* 36016-17 (Sept. 16, 1988).

[23] See discussion at 53 *Fed. Reg.* 36016-17 (Sept. 16, 1988).

[24] *Id.*

[25] United States General Accounting Office. *Private Health Insurance: Continued Erosion of Coverage Linked to Cost Pressures.* GAO/HEHS-97-122 (July 1997), 35.

[26] Workers in low-wage firms are also less likely than workers in other firms to be offered health benefits and to be eligible for coverage when it is offered (Stephen H. Long and M. Susan Marquis, *Employment-Based Insurance: Recent Trends and Coverage for Low-Wage Workers (Preliminary Results)*. Rand (October 5, 1999), 20.

[27] For example, health insurance coverage accounts for nearly 10 percent of expenditures for households with incomes below $10,000, while for households with incomes at or above $30,000, health insurance accounts for 2 percent of expenditures. Unpublished estimates by the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, using the 1997 Consumer Expenditure Survey.

[28] The average group premium ranged from $1,883 to $2,090 depending on plan type. Employee Benefits Institute. *EBRI Databook on Employee Benefits* (1997). See http://www.ebri.org/facts/0997fact.htm

[29] Employee Benefits Institute. *EBRI Databook on Employee Benefits* (1997). See http://www.ebri.org/facts/0997fact.htm

[30] Gabel, Jon R., Paul B. Ginsberg, and Kelly A. Hunt. "Small Employers and Their Health Benefits, 1988-1996: An Awkward Adolescence." *Health Affairs* (September/October 1997), 107. It is not surprising that nearly 40 percent of uninsured children live in families whose parent(s) worked in firms employing less than 25 employees, while just under 20 percent of uninsured children were in families where their parent(s) were employed in a company with 1,000 or more workers. Children were categorized by the size of the largest firm employing either parent.

Based on 1998 Current Population Survey estimates in Committee on Ways and Means, U.S. House of Representatives. *Medicare and Health Care Chart Book* (May 17, 1999), 56.

[31] In 1995, the average child support received was $3,373 (Lydia Scoon-Rogers, "Child Support for Custodial Mothers and Fathers: 1995," *Census Bureau Current Populations Reports* (March 1999), 60-196.)

[32] See, Laura Morgan, Child Support Guidelines, §3.01, and discussion under Recommendation 1 *supra* for more detail on this.

[33] States raised this issue as early as 1988 when they were required to aggressively pursue private coverage for children receiving Medicaid even when this caused a drop in cash support. Prior to this time, States had to pursue private coverage only when the cost of family health coverage did not affect the noncustodial parent's ability to pay cash support. 53 *Fed. Reg.*36015 (Sept. 16, 1988).

[34] See, for example, Frank Furstenberg, Kay Sherwood, and Mercer Sullivan, *Caring And Paying: What Fathers And Mothers Say About Child Support*, Manpower Demonstration Research Corporation (1992).

[35] Wash. Rev. Code §26.09.105(1) (1999). Also, the decision maker can order the parent to provide insurance that exceeds 25 percent of the basic child support obligation if it is in the best interest of the child. Wash. Rev. Code §26.09.105(2).

[36] Colo. Rev. Stat. Ann. §14-10-115(g) (1999).

[37] Me. Rev. Stat. Ann. tit.19A §2007(1998).

[38] Montana Code Annotated (MCA) 40-5-806(a)(8).

[39] Pirog, Maureen A., Marilyn E. Klotz, and Katharine V. Byers. "Interstate Comparisons of Child Support Orders Using State Guidelines." *Family Relations* 27(8): 291.

[40] We also considered recommending a variable percentage based on the parent's income. However, we concluded that this approach was complex to administer and would not necessarily achieve better results than a flat percentage.

[41] The Colorado Department of Health Care Policy and Financing had designed and implemented the "Safety Net Project" to improve service delivery and care coordination for children with special needs in HMOs.

[42] 29 U.S.C. §1161 (1999). See also Recommendations regarding COBRA/HIPAA in Chapter 6.

[43] Arizona Ariz. C.S.G. (S. Ct. Admin Order 96-29) (1998), Idaho, Idaho R. Civ. Pro. 6(c)(6) §8(c)(1)(1999); Massachusetts, Mass. Ann. Laws, Child Support Guidelines, II-G (1999); South Carolina, S.C. Code Regs. 114-4720 (1999); and Wyoming, Wyo. Stat. Ann. 20-6-302(b)(viii)(1999). Tex. Fam. Code §154.182, requires the court to consider insurance available to the obligee, only if the obligor does not have access to coverage for the child through his/her employer, union, trade association or other organization.

[44] The Arizona guideline States: "An order for child support shall assign responsibility for providing medical insurance for the children who are the subject of the support order. If medical insurance of comparable benefits and cost is available to both parents, the court should assign the responsibility to the parent having primary physical custody." Ariz. C.S.G. (S. Ct. Admin. Order 96-29 (1998).

[45] Massachusetts provides that, if the custodial parent is already covering the children at the time the order is entered, then he/she can opt to continue that coverage even if the noncustodial parent has access to coverage, Mass. Ann. Laws, Child Support Guidelines, II-G (1999).

[46] Unpublished calculation from HHS/Office of the Assistant Secretary for Planning and Evaluation based on the 1995 CPS Child Support Supplement. See APPENDIX D: Health Care Coverage for Child Support-Eligible Children, page A-32.

[47] For a summary of the law in this area see Laura Morgan, "The Duty of Step-Parents to Support Their Step-Children," in *Divorce Litigation* (September 1996). An updated version is available on the web at http://www.supportguidelines.com/articles.

[48] These States are Delaware, Hawaii, Iowa, Kentucky, Maine, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Vermont and Washington.

[49] See, for example, Jocelyn Guyer and Cindy Mann, "Employed But Not Insured," Center on Budget and Policy Priorities (1999).

[50] The Working group was provided extensive information about one of these programs, the Sacramento (California) IV-D KIDS program. We also received information about a similar program in Montana. Chapter 8 sets out the Working Group's recommendations for encouraging similar efforts elsewhere.

[51] Conn. Agencies Regs. §46b-215a-2a(g)(1)(B)(1999).

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[52] Tex. Fam. Code §154.182(b)(4) (1999).

[53] 42 U.S.C. §1396e.

[54] 42 U.S.C. §1396a(a)(10)(F).

[55] Current HCFA policy is that this can be done for employer-sponsored insurance if: 1) the children have been insured for at least 6 months; 2) at least 60 percent of family premium costs are paid for by the employer; and 3) the costs to the State do not exceed the cost of SCHIP coverage. (Policy under development pending final SCHIP rule.)

[56] See http://www.hcfa.gov/

[57] DCL 97-91 from Commissioner David Gray Ross to all IV-D Directors, dated December 6, 1997.

[58] 42 U.S.C. §1396a (1999).

[59] The law allows a child to have private coverage and be enrolled in Medicaid. In a limited number of cases, the IV-D agency might also find that there is limited private coverage available to the child. It could order this coverage and enroll the child in Medicaid, assuring more comprehensive services to the child.

[60] 42 U.S.C. 1397bb(b) (1999).

[61] As of June 1999, Connecticut, Georgia, Minnesota, Missouri, New Hampshire, New Mexico, Rhode Island and Vermont extended eligibility above the 200 percent of poverty level.

[62] 42 U.S.C. §1397cc(e) (1999). Twenty- three States have a simple Medicaid expansion, while 33 have created a separate CHIP program. (Of the 33 with separate programs, 15 States have all of their CHIP-eligibles in a separate program, and 18 have a hybrid model with some CHIP eligibles in Medicaid and some in a separate program.)

[63] As of June 1999, 23 States had developed policies under which the parents of CHIP-eligible children are asked to contribute toward the CHIP premium. These States are Alabama, California, Colorado, Connecticut, Delaware, Florida, Georgia, Illinois, Iowa, Kansas, Kentucky, Maine, Massachusetts, Michigan, Missouri, Montana, Nevada, Nebraska, New York, North Carolina, Rhode island, Vermont and Wisconsin.

[64] 42 U.S.C. §1397cc(e)(3)(A) (1999).

[65] 42 U.S.C. §1397cc(e)(3)(B) (1999).

[66] At least 30 States have such laws on their books. These States are Alabama, Arizona, California, Colorado, Delaware, Hawaii, Iowa, Kentucky, Maine, Maryland, Michigan, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Dakota, Ohio, Oklahoma, Rhode Island, South Dakota, Tennessee, Utah , Washington, Wisconsin, and Wyoming.

[67] Indeed, the Institute calculated that there would be $3.38 in savings for every $1.00 of public funds spent on prenatal care. The Institute's report is discussed extensively in *Lewis v. Grinker*, 965 F.2d 4904 (2d Cir. 1992).

[68] The title of the report is *For the Children of Tomorrow.*

[69] 42 USC §1396k(a)(1)(B). See also 45 CFR §433.145(a)(2) and §433.147(a).

[70] See, H. Rpt. No. 101-881, 101st Cong. 2d Sess. 106-107 (1990), reprinted in 1990 U.S. Code Cong. & Admin. News 2017, 2118-2119.

[71] See, for example, *Matter of Steuben County v. Deats,* 76 N.Y.2d 451, 560 N.Y. Supp. 2d 404 (1990); *Perry v. Dowling,* 963 F. Supp. 231 (W.D. N.Y. 1997).

[72] 42 USC §666(a)(5)(C).

[73] *Id.* §658a(b)(6)(A).

[74] *Id.* §609(a)(5).

[75] Wheaton (2000),15.

[76] Laura Morgan, Child Support Guidelines, Chapter 3, §301(b)(3).

[77] Morgan, Child Support Guidelines.

[78] Jane Venohr and Robert Williams, *The Implementation and Periodic review of State Child Support Guidelines,* 33 *Family Law Quarterly* 7 (Spring 1999), Table 4, 19.

CHAPTER 4.

Implementing a New Tool: The National Medical Support Notice and Related Issues

National Medical Support Notice

Background

Health care coverage for children living in a single-parent home can be enforced through a medical child support order in private domestic relations proceedings or as the result of State IV-D agency efforts to establish and/or enforce medical child support obligations. Congress amended ERISA in 1993,[1] requiring group health plans to provide benefits in accordance with the provisions of any QMCSO. This was not enough, as child support enforcement agencies have rapidly moved to automated, administrative processes to secure obligations. The QMCSO requirements may be interpreted to require the IV-D agency to obtain specific information to tailor an order in compliance with those requirements, a labor intensive ("by the each") process. Thus, the conflicts between the QMCSO requirements and the need of State agencies to automate

ERISA
Employee Retirement Income Security Act of 1974

QMCSO
Qualified Medical Child Support Order

CHAPTER 4 AT A GLANCE

NATIONAL MEDICAL SUPPORT NOTICE, 4-1
- *Background, 4-1*
- *The Notice and ERISA, 4-3*
  - Domestic Violence Issues, 4-4
- *High-Volume Administrative Enforcement, 4-4*
- *Timetable: NPRM, Final Rule, State Legislation, 4-6*
- *Overview of Notice, 4-6*
- *Working Group's Discussion of the Notice, 4-8*

RECOMMENDATIONS OF THE WORKING GROUP ON MAKING THE NOTICE WORK BETTER, 4-10
- *Program Implementation Issues, 4-10*

COVERAGE FOR CHILDREN OF FEDERAL EMPLOYEES AND MILITARY PERSONNEL, 4-13

Theme

The National Medical Support Notice is intended to provide a standardized means of communication between State child support enforcement agencies, employers, and administrators of group health plans regarding the medical support obligations of noncustodial parents. The Notice will facilitate the process of enrolling children in the group health plans for which their noncustodial parents are eligible. While the Notice that has been proposed would go a long way towards improving medical support enforcement, there are changes that can be made that will further simplify and streamline the process and make it less burdensome to all the parties involved. Steps also should be taken to make the Notice applicable to the Federal civilian and military health care plans.

their enforcement procedures have frustrated attempts to enroll children in noncustodial parents' group health plans. There are several reasons for continued frustration.

CSPIA
Child Support Performance and Incentive Act of 1998

- Prior to CSPIA, there was no clearly defined "tool" to enforce medical support obligations, as there was to enforce child support (income withholding notice).

OBRA
Omnibus Budget Reconciliation Act of 1993

- The OBRA '93 amendments contained highly individualized and specific requirements that each order had to satisfy to be "qualified" by an ERISA plan administrator.
- The wide variety of notices and orders that various States use to enforce medical child support obligations, and the failure of many of these orders to comply with ERISA requirements, frequently confuses and frustrates employers, plan administrators, and State IV-D agencies. As a result, children face unnecessary delays or denials when attempting to enroll in their noncustodial parent's group health coverage.
- Plan administrators often do not agree on which notices and orders satisfy ERISA requirements and State IV-D agency personnel are often unfamiliar with those requirements.
- Because a degree of standardization is essential to optimal use of automated systems, the lack of uniformity or standardization among plan requirements and "qualified" medical support orders also precluded the effective use of automation to facilitate the implementation and enforcement of medical support obligation services by IV-D agencies.

> *"We want the notice to be as standardized as possible, the actual form itself, so that ...an employer or a plan getting one of these things knows that ... all the information is going to appear in roughly the same place irrespective of whether it comes from West Virginia or New York or Washington."*
>
> **~Nell Hennessy, Senior Vice President, Actuarial Sciences Associates, Inc.**

- This lack of uniformity or standardization among plan requirements—and hence, the content of a "qualified" medical support order—required IV-D agency staff to invest significant time and effort in determining each plan's standard for qualifying a medical child support order and obtaining the information necessary to satisfy that particular standard.
- The methods States use for communicating with all the associated parties vary widely.
- Where a medical support provision of a child support order has been rejected by the plan administrator, there is presently no streamlined mechanism to appeal that decision. Hence, the Working Group's focus is on ensuring the document forwarded to the plan administrator is legally sufficient to avoid delay or denial.

NMSN
National Medical Support Notice

The provisions of CSPIA that relate to the NMSN were intended to alleviate some of those problems.[2] Specifically, CSPIA directed the Secretaries of Labor and of HHS to jointly develop and promulgate by regulation a National Medical Support Notice.[3] The same law amended ERISA[4] to require the administrator of a noncustodial parent's employment-related group health plan to deem an appropriately completed Notice (that also satisfies the QMCSO requirements) to be a QMCSO for the child and to implement coverage in a timely manner.[5] This "deeming" provision and time-limited responses are critical to the IV-D agency's implementation of medical support in an expeditious and automated fashion.

> *"What we want to do is facilitate and streamline efforts to get children enrolled in health insurance, and not bog this whole process down in red tape... to where the children are delayed from being enrolled in available insurance."*
>
> **–Michael Generali, Intergovernmental Liaison for the Child Support Division, Office of the Attorney General, Texas**

The Notice and ERISA

CSPIA requires the NMSN to conform to the requirements of §609(a) of ERISA[6] and to Title IV-D of the Social Security Act;[7] it also requires IV-D agencies to issue the Notice to the employer of a noncustodial parent when alternative coverage is not provided for in a child support order. In recognition of employer concerns that the form be made easily accessible to the various parties who may have to deal with it, Congress directed that the form be "easily severable" so that the sections could be handled by the employer and by the plan administrator, if different from the employer. Amendments to §466(a)(19)[8] of the Social Security Act require States to enact laws that mandate State agencies' use the Notice as the prescribed method of enforcing the health care coverage provisions in child support orders. This will

NMSN or QMCSO: What's the Difference?

For IV-D agencies, there really is not a difference between an NMSN and a QMCSO. The NMSN is merely a subset of QMCSOs that will be issued by the IV-D agencies. (Remember that a QMCSO may be a judgment, decree, or order issued by a court of competent jurisdiction through an administrative process that has the force and effect of law, or an administrative notice that is issued through such an administrative process.) CSPIA mandated the development of the NMSN as a uniform medical child support order (for the purposes of this Report, any reference to a medical child support order includes, with respect to IV-D agencies, administrative notices that may be issued by such agencies to enforce the medical support provisions of a child support order, including the NMSN) to be issued by State IV-D agencies and that would, if appropriately completed, be deemed to be a QMCSO. However, a NMSN is still subject to all of the procedural requirements that any QMCSO is subject to, including a determination by the plan administrator of whether it is qualified. Custodial parents seeking to enforce the medical child support obligations of the noncustodial parent through their own means will continue to present the court or administrative order to the group health plan for a determination of whether it is a QMCSO.

ensure that plan administrators receive uniform notices from child support agencies in every State.[9]

If the administrator of a noncustodial parent's ERISA-covered group health plan receives an appropriately completed Notice that has been issued by a IV-D agency and that satisfies the requirements of §609(a) of ERISA, that Notice must be deemed a QMCSO. Within 40 business days after the date of the Notice the plan administrator must notify the issuing agency whether coverage is available to the child named in the Notice. The child's custodial parent or a substituted State official must be provided with a description of coverage available under the plan and any forms or documents necessary to effectuate such coverage.[10]

See Recommendation 27.

Domestic Violence Issues

ERISA originally provided that a medical child support order would be deemed a QMCSO only if the order clearly specified, among other things, the name and mailing address of each child covered by the order. However, State and Federal law prohibit the disclosure of the child's and custodial parent's address in cases in which there is an identified possibility of domestic violence or abuse.[11] The child support enforcement agencies were thus unable to craft medical child support orders that would be qualified in cases in which they were prohibited from disclosing the child's address. Congress responded by amending ERISA to permit the court or administrative agency to substitute the name and mailing address of an official of a State or of a political subdivision of the State for the mailing address of the child.[12]

High-Volume Administrative Enforcement

The use of automation has been critical in the effort to streamline case processing and data accuracy and to improve program performance. Based on the experience of the States, the Working Group concluded that automated systems could facilitate medical support enforcement by expediting the transmission of required data and the submission of time-sensitive responses. Central and State systems staff indicated that these modifications would be relatively simple and require approximately six months to complete. The Working Group

Recommendation 27 (Federal Guidance)

DOL and HHS should: (1) make it clear that the Notice is deemed to be a Qualified Medical Support Order only if issued by IV-D agencies, and (2) explain how the QMCSO process works for private parties. (See Recommendation 25) determined that State child support enforcement automated systems should be modified, at a minimum, so that they could:

- Produce the form to be used as the prescribed Notice
- Pre-file common case identification data
- Automatically create entries in case chronology files, which record when and to whom a Notice was sent
- Receive and record information about the availability of health care coverage from custodial and noncustodial parents as well as employers and plan administrators
- Communicate information to TANF and Medical Assistance agencies and to custodial parents

TANF
Temporary Assistance for Needy Families

The Working Group considered the feasibility of establishing mainframe-to-mainframe computer or Internet linkages between State child support databases and other entities involved in the Notice implementation process, including those of employers/plan administrators, Medicaid, and SCHIP. The Working Group *did not recommend* establishment of such linkages. This is an important issue that needs further study. See Recommendation 28.

See CHAPTER 8.

States report that they continue to be preoccupied with ensuring that their child support enforcement automated systems meet PRWORA certification requirements. For this reason, most states will not be able to begin modifying their systems to address medical support requirements until after October 1, 2000. This timing correlates with the projected September 2000 publication date of Final Regulations promulgating the NMSN, and with the possible availability of enhanced Federal funding to assist in financing these modifications, as proposed in Recommendation 65.

PRWORA
Personal Responsibility and Work Opportunity Reconciliation Act of 1996

The Working Group considered whether the NMSN and the Order/Notice to Withhold Income for Child Support should be combined into one form. Employer representatives stated that this would be administratively burdensome, especially for large multistate employers; they also observed that this would frequently cause unnecessary delays in enrolling children in required health care coverage. Representatives of employers and insurers explained that large, multistate employers

Recommendation 28 (Technical Assistance)

The DOL and HHS should collaborate with State IV-D agencies and organizations representing employers, plan administrators, and payroll agents to develop automated State IV-D systems that can produce the National Medical Support Notices and distribute these Notices and their responses to affected parties.

frequently separate payroll and health plan administration. The component that would process the NMSN and the one that processes the Order/Notice to Withhold Income for Child Support are not only administratively separate, but are often located in different parts of the country. CSPIA allows, and the Working Group concluded, that these two forms remain separate.

Timetable: NPRM, Final Rule, State Legislation

CSPIA specifically directed the Working Group to make recommendations based on assessments of the form and content of the NMSN as issued under regulations.[13] To enable its members to become familiar with the issues considered by the agencies responsible for developing the Notice, the Working Group invited staff of HHS and DOL to attend Working Group meetings. Federal staff attended several meetings, provided overviews of the proposed Notice, and shared their views regarding the relevant issues.[14] As a result of this collaboration, the Working Group's recommendations are reflected in the proposed Notice promulgated by the agencies.

In an effort to ensure that the NMSN would facilitate rather than complicate State agency efforts to secure health care coverage for children—as is consistent with Congressional intent as well as the concerns of the Working Group—the Working Group recommended, and the agencies agreed, that the Notice should be promulgated in a proposed regulation rather than as interim regulations. Notices of Proposed Rule Making (NPRM), promulgating the NMSN, were published in the *Federal Register* on November 15, 1999. The recommendations contained in this chapter regarding the NMSN are based on the Working Group's review of the NPRM.

Overview of Notice

The proposed NMSN is comprised of two parts: Part A, the Employer Withholding Notice, and Part B, the Medical Support Notice to the Plan Administrator. Each part includes information to be provided by the State IV-D agency, including the names and mailing addresses of the employee/obligor, the child and the employer, and the type of coverage to be provided, such as basic, dental, vision, mental health and prescription. They also contain information related to the underlying child support order, such as the date of the order and the court or agency issuing the order.

Part A includes an Employer Response form. If the employer does not offer group health coverage, or if the employee is among a class of employees that is not eligible for family coverage under the employer's plans, or if the employee is not employed by the employer, the employer checks the appropriate box and returns the Response Form to the State agency. Otherwise, the employer forwards Part B to the appropriate plan administrator.

If, after receiving enrollment information from the plan administrator, the employer determines that State or Federal withholding limitations prevent withholding the required employee contribution to obtain coverage, the employer checks the appropriate box to indicate that withholding limits apply and returns Part A to the State agency.

The instructions to Part A inform the employer of the following:

- The employer's responsibilities with respect to the Notice, including its obligation to forward Part B to the administrator of each group health plan in which the child may be eligible to enroll
- The limitations on and priority of withholding
- The duration of the withholding obligation
- Possible sanctions to which the employer may be subject
- The employer's obligation to notify the State agency if the employee's employment terminates
- The employee's liability for making any necessary employee contributions to the plan
- A means to contact the State agency with any questions

The Working Group's proposed Notice and recommendations on that Notice are contained in APPENDIX E: National Medical Support Notice, page A-37.

The Plan Administrator Response form in Part B notifies the State agency of the following:

- Any defects in the Notice
- When it was determined to be a QMCSO
- Either that the child has been enrolled in the plan, or of the options available
- The effective date of coverage and the option selected in which the child will be enrolled, including a description of the plan

The instructions to the Plan Administrator inform the plan administrator of her responsibilities with respect to the Notice, including the following:

- Informing the parties when coverage is effective
- Providing a description of the coverage
- Providing the custodial parent with forms, documents and information necessary to effectuate coverage
- Notifying the participant that his coverage may be changed by the IV-D agency, based on an election made for the child.

The instructions also inform the administrator that the child may not be denied coverage on the ground that the child was born out of wedlock, is not claimed as a dependent on the participant's Federal income tax return, or does not reside with the participant, and that enrollments must be made without regard to open season restrictions. In addition, the instructions inform the administrator that the child is to be treated as a dependent under the terms of the plan and that the child may be entitled to COBRA continuation coverage under certain circumstances. Finally, the instructions set forth the conditions under which the child may be dis-enrolled from the plan.

Working Group's Discussion of the Notice

After review and assessment of the form and content of the Notice as issued under proposed regulations published in the *Federal Register* on November 15, 1999, it is the consensus of the Working Group that this proposed Notice conforms with applicable Title IV-D and ERISA requirements and other mandatory standards, as required by CSPIA. Further, the Working Group believes that, when implemented and properly completed, the proposed Notice will be an effective and valuable asset to States in enforcing the medical support obligations of noncustodial parents. It is essential that the proposed Notice be simple, easy to understand and, as far as possible, similar in format to the Order/Notice to Withhold Income for Child Support. The Working Group made several significant recommendations on the Notice, as discussed below. Based on the above, the Working Group recommends that the final rule for the NMSN should be published by September 2000 to allow States sufficient time to implement automated processes by October 1, 2001. See Recommendation 29.

The Working Group determined that user familiarity, timely transmission of required data, and good coordination between involved parties are important keys to the effective use of the proposed Notice. The Working Group recommends that DOL/HHS implement strategies to reach out to and educate representatives of all of the groups that have a need for, or interest in, use of the Notice. An easy-to-understand

Recommendation 29 (Federal Regulation)

HHS and DOL should publish the National Medical Support Notice in final form no later than September 1, 2000 to allow States sufficient time to implement automated processes by October 1, 2001 booklet similar to HHS' *The Employer's Desk Guide to Child Support* and DOL's booklet on Qualified Domestic Relations Orders (QDROs) was discussed as a possible component of this strategy. The booklet could provide guidance with respect

Recommendation 30 (Education/Technical Assistance)

The DOL and HHS should develop strategies to educate and reach out to all categories of constituents who have a need for, or interest in, the National Medical Support Notice, including the following categories of constituents:

American Bar Association
State and Local Bar Associations
State Courts
Private Attorneys
American Payroll Association
Child Support Organizations (NCSEA, ERICSA, WICSEC)
National Coordinating Committee for Multi-employer Plans
AFL-CIO
International Foundation of Employee Benefit Plans
Association of Private Pension and Welfare Plans
ERISA Industry Committee
Society of Professional Benefit Administrators
National Association of Insurance Commissioners
Society for Human Resource Management
Native American Tribes
Federal Government
Military
Faith-Based Organizations
State and local governments

Recommendation 31 (Education and Technical Assistance)

DOL and HHS should reach out to courts and administrative authorities to educate them regarding the Notice and the health coverage data required for completion.

Recommendation 32 (Education/Technical Assistance)

The DOL and HHS should draft an easy-to-understand booklet similar to HHS's *The Employer's Desk Guide to Child Support* and DOL's booklet on *Qualified Domestic Relations Orders (QDRO) under ERISA*. The booklet should explain the National Medical Support Notice and the DOL's views and interpretations of ERISA's Qualified Medical Child Support Order (QMCSO) provisions.

Recommendation 33 (Federal Guidance)

The DOL should inform employers, insurers, and plan administrators that when a noncustodial parent carries health care coverage for a child, and the provider of services or the custodial parent of such child submits the claim, 42 USC §1396g(a)(5) requires the insurer to pay the person or entity that submits the claim to the same extent the employee is entitled to be paid.

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to the use of the NMSN, as well as the general ERISA provisions governing QMCSOs. 📄 See Recommendation 30, Recommendation 31, Recommendation 32, Recommendation 33.

Recommendations of the Working Group on Making the Notice Work Better

The Working Group made a number of recommendations, which it believes will further enhance the effectiveness of the Notice. The recommendations are divided into two categories. The first category—identified as ***Notice Process Recommendations***—are intended to improve the effectiveness of the Notice. The second category—identified as ***Technical Notice Comments***—suggest technical changes to the Notice that the Working Group believes will help to improve the effectiveness, simplicity and/or the readability of the proposed Notice itself. These latter recommendations are contained in APPENDIX E: National Medical Support Notice (page A-37) together with the Working Group's Recommended Notice.

Program Implementation Issues

The Working Group also discussed the importance of State IV-D agencies issuing release notices to employers when noncustodial parents' medical support obligations under a child support order terminate (such as the notice used by Washington State). Standard forms make it easier for employers and plan administrators to cooperate with child support agencies in medical child support cases. However, the Working Group rejected the idea of including a release notice as an integral part of the NMSN, because this would unnecessarily complicate a notice that was intended primarily for enrollment purposes. 📄 See Recommendation 34.

☞ See APPENDIX F: Washington State Model Notice of Release Form, pageA-55.

The Working Group also approved requiring employers to send copies of any COBRA notices related to a child's loss of health coverage to any child support agency that has issued a medical child support order to the plan. The Working Group recognizes that it is important for children to have continuous health care coverage. Plans are currently required to send COBRA notices when a child loses coverage for specified

📄 **Recommendation 34 (Technical Assistance)**

The DOL and HHS should develop and make available to States a suggested model "Notice of Release" that State IV-D agencies may issue to employers when a noncustodial parent's obligation to provide health care coverage terminates.

COBRA events. A child support enforcement agency that has issued a NMSN to a plan also needs to receive copies of any COBRA notices related to the child's loss of health care coverage so that it can decide whether to enroll the child in COBRA or other alternative coverage. Unless child support agencies are notified of the impending loss of insurance, the coverage may lapse, and the child will probably be uninsured. At the same time, the burden of sending an identical COBRA notice to the IV-D agency is not significant since the plan is already required to prepare and send the notice to the child (in reality, the custodial parent). See Recommendation 35.

As discussed above, Congress amended §609(a) of ERISA to permit the court or administrative agency issuing the order to substitute the name and mailing address of an official of a State (or of a political subdivision of the State) for the mailing address of the child in the order. The proposed NMSN promulgated by DOL and HHS has made provision for such substitution.

However, in cases where a State official's name and address have been substituted for the child's address on an NMSN, the administrator of a plan that provides benefits only in a geographically limited area (or which has one or more options that provide benefits only in a geographically limited area) may be unable to determine whether the child is in or close to the service area of the plan (or any of the geographically limited options). Disclosing the child's approximate location might increase the risk of domestic violence to the custodial parent or child. Accordingly, the Working Group recommends that the plan administrator provide information to the child support enforcement agency, so that the agency can determine whether the coverage (or any options) is accessible, as defined in Recommendation 8. See Recommendation 36, Recommendation 37, and Recommendation 38.

The Working Group also considered whether the employer—prior to forwarding Part B to the plan administrator—should determine whether the State or Federal CCPA limits would prevent withholding of sufficient amounts from the employee's wages to pay any employee contributions

Recommendation 35 (Federal Legislation)

Congress should enact legislation requiring health care plans to send a copy of any COBRA notice related to a child's loss of health coverage to the State IV-D agency *if* the health care plan received any QMCSO, including the National Medical Support Notice for that child, from the IV-D agency.

necessary to obtain coverage for the child under the plan. However, employers representatives indicated that payroll offices, where such determinations are made, often do not have information related to the employee contributions required by the group health plan.

This lack of information is more significant in cases in which there are different employee contributions required for different options available under the plan, and in the case of collectively bargained multiemployer plans. Accordingly, the Working Group determined that it would not be reasonable to require the employer to make determinations regarding withholding limitations prior to the plan administrator's determination of whether the Notice is qualified.

Recommendation 36 (Federal Regulation)

[illegible] or [illegible] of the options under a health care plan are limited to specified [illegible] service areas, such as those covered by specific zip codes, then:

- [illegible] plan administrator should indicate that geographic restrictions apply and should provide information that would make it possible for the IV-D agency to determine whether the coverage is accessible to a child (see Recommendation 8).
- The plan administrator should be instructed to enroll the child, unless the IV-D agency requests that a child not be enrolled, even if the only available plan coverage is geographically limited and the child is outside the plan's service area.

Recommendation 37 (Federal Regulation)

If the plan administrator cannot determine a child's zip code or location from the Notice because [illegible] Substitute Official's address is used, the plan administrator should be instructed to contact the IV-D agency and provide sufficient information to permit the agency to decide whether or not the coverage is accessible as defined in Recommendation 8.

Recommendation 38 (Best Practice)

In situations in which the IV-D agency is advised that a choice is required with regard to plan options, the agency should do the following:

- If there is a Medicaid assignment in effect, the IV-D agency should consult with the custodial parent and the Medicaid agency, review the State's treatment of coverage under child support guidelines, choose the appropriate option consistent with the best interests of the child, and notify the plan.
- If there is no Medicaid assignment in effect, the IV-D agency should contact the custodial parent regarding the options, review such options in light of the State's treatment of coverage under the child support guidelines, ascertain the custodial parent's choice, and notify the plan.

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Coverage for Children of Federal Employees and Military Personnel

Since the passage of the OBRA' 93, States have been required to enact laws under which employers and insurers must enroll a child in health coverage upon application by the custodial parent or IV-D agency in instances when a court or administrative agency orders an obligor to provide health coverage for a child and the obligor is eligible for such coverage but fails to enroll the child.[15]

Ironically, Federal law specifically bars the Federal government and the armed forces from enrolling dependents unless requested to do so by the employee from whom they derive coverage.[16] This means that a substantial number of children who could obtain private coverage through a parent who is employed by the Federal government or the armed forces are unable to obtain this coverage unless the employee makes the request. It also appears to be inequitable for the Federal government to subject all employers except itself and the armed forces from this involuntary enrollment policy.

There have been efforts over the last few years to address this issue, including introduction of legislation in the current Congress.[17] The Working Group believes Congress should enact such legislation as quickly as possible.

In conjunction with this, Congress should also clarify that the provisions of §1908 that prohibit employers from discriminating against dependents who are non-marital children, do not live with the employee, and/or who are applying out of season also apply to the Federal government. See

Recommendation 39 (Federal Regulation)

If an employee is in a waiting period that will expire within 90 days after the receipt date of the Notice, then the plan administrator should (1) determine whether the Notice is a qualified order and (2) notify the IV-D agency and the parents of the date on which coverage will begin

If the waiting period expires more than 90 days after the receipt of the Notice, or if the duration of the waiting period is determined by some measure other than the passage of time (for example, the completion of a certain number of hours worked), then once the plan administrator has determined that the Notice is a qualified order, the plan administrator would describe the waiting period on the portion of the Notice returned to the IV-D agency (Part B), and the employer would notify the plan administrator when the employee is eligible to enroll in the plan and when a NMSN is in effect with respect to one or more children of the employee. The plan administrator then notifies both parents.

Recommendation 41, Recommendation 42, Recommendation 43.

The Working Group believes that implementing the NMSN, together with these recommendations, will make it possible for child support agencies to enroll more children in private medical insurance, help avoid lapses in children's health care coverage, and increase the efficiency and effectiveness of IV-D agencies' medical support enforcement activities.

Recommendation 40 (Best Practice/Guidance/Technical Assistance/Notice Comments)

Where the court determines that a pattern of misappropriation of insurance payments exists, the court may, at its discretion, order the insurer to pay all claims for reimbursement directly to the provider of services. This provision should be binding on all parties.

Recommendation 41 (Technical Assistance)

The DOL and HHS should work with agencies that administer health plans for Federal workers and the military (OPM and DOD) to develop procedures that will recognize the Notice as a means to enroll children in their plans. (See Recommendation 42and Recommendation 43)

Recommendation 42 (Federal Legislation)

Congress should enact legislation that would allow Federal agencies to enroll Federal employees and their dependents in the Federal Employees Health Benefits Program without the employee's consent if the employee is ordered to provide such coverage for his or her dependent(s).

Recommendation 43 (Federal Legislation)

Congress should enact legislation to allow the U.S. military to enroll its employees and their dependents in Tri-Care without the employee's consent if the employee is ordered to provide such coverage for his or her dependents.

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Endnotes

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[1] Pub. L. 103-66 §4301(a), 107 Stat. 371 (1998), codified at 29 U.S.C. § 1169 (1999).

[2] 42 U.S.C. §466(a)(19)was amended in the following way – By Oct. 1, 2001 (or the next time the State legislature meets), all IV-D child support orders with a medical support component must be enforced, where appropriate, using the National Notice unless alternate coverage is allowed in the child support order. If the noncustodial parent is located through the New Hire directory, states must provide, where appropriate, the National Notice together with an income withholding notice in two days after the date of entry in the State New Hire directory.

[3] Pub. L. 105-200, §401(b) (1998), codified at 42 U.S.C. §651 note (1999).

[4] 29 U.S.C. §1169(a)(5)(C) (1999).

[5] 29 U.S.C. §1169(a)(5)(C)(ii)(1999).

[6] 29 U.S.C. §1169(a) (1999).

[7] Title IV-D of the Social Security Act, 42 U.S.C. §1396g-1 (1999), requires States to have laws under which employers and insurers must enroll a child in health coverage upon application by the custodial parent or IV-D agency when a court or administrative agency orders an obligor to provide health coverage for a child and the obligor is eligible for such coverage but fails to enroll the child.

[8] 42 U.S.C. §666(a)(19)(1998).

[9] Similar concerns regarding uniformity led to the development of the current Order/Notice to Withhold Income for Child Support. Prior to 1998, the form and content of notices and orders used by States to notify employers of the financial support obligations of noncustodial parents also varied widely. This lack of uniformity also led to confusion and unnecessary delays. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, among other things, requires States to transmit to employers (and other debtors) no later than October 1, 1998, orders and notices for income withholding using a uniform format prescribed by the Secretary of HHS. Following this directive, the Federal Office of Child Support Enforcement worked with State child support enforcement agencies and representatives from the American Payroll Association, the American Society of Payroll Management, and employers groups to develop the Order/Notice to Withhold Income for Child Support. In January 1998, this form was issued to the States, and currently is used as the prescribed format in processing child support wage attachments in the Child Support Enforcement Program. Use of this form by State agencies has greatly simplified the process of wage withholding.

[10] 29 U.S.C. §1169(a) (5)(C) (1998).

[11] See, e.g. 42 U.S.C. 654(26)(B).

[12] 29 U.S.C. §1169(a)(3)(A) (1999).

[13] CSPIA, §401(a)(5)(A)(i), 112 Stat. 660 (1998).

[14] A significant part of the Working Group's April 13, 1999, meeting was devoted to a discussion and preliminary assessment of the then current draft, which was provided to members of the Working Group. The Working Group concluded that the April draft Notice did not adequately address the needs and interests of all the parties who would be affected by it, and that members needed additional time to review and comment on subsequent drafts of the Notice, prior to its promulgation by regulation. Working Group members also expressed concern that employers and plan administrators would be required to comply with interim regulations immediately upon their publication in States that chose to implement the Notice before the mandatory implementation date, October 1, 2001. The full Working Group considered a revised draft of a proposed Notice at its May 1999 meeting.

[15] Section 1908 of the Social Security Act, 42 U.S.C. §1396g-1 (1999).

[16] 5 USC §8905 (1999).

[17] H.R. 2842, 106th Cong. 1st Sess. was introduced on September 13, 1999 and referred to the Committee on Government Reform.

CHAPTER 5. Answering Hard Questions: Providing Guidance to IV-D Agencies and Employers on Enforcement Issues

Introduction

Child support enforcement agencies are required to enforce the medical support provisions of child support orders for all IV-D cases.[1] For a number of reasons, however, such enforcement has proven difficult. For example, the parents may live in different States, or neither parent may have access to medical coverage at the time the child support order is originally entered.

When it passed CSPIA, Congress instructed the Working Group to examine some of the issues surrounding medical support enforcement, particularly those related to the Federal CCPA and the priority of withholding.[2] In its examination of these issues, the Working Group also discovered a number of other problems that needed to be addressed and has made recommendations to remedy these issues as well. These recommendations also reflect the need to address new enforcement issues that will arise once the Working Group's recommendations regarding the establishment of orders have been implemented.

CSPIA
Child Support Performance and Incentive Act of 1998

CCPA
Consumer Credit Protection Act

CHAPTER 5 AT A GLANCE

- INTRODUCTION, 5-1
- ENFORCEMENT OF HEALTH CARE PROVISIONS OF CHILD SUPPORT ORDERS, 5-2
  - *Enforcing Orders to Provide Family Health Coverage, 5-2*
    - Enforcement Issues in Interstate Child Support Cases, 5-3
  - *Monitoring and Enforcing Custodial Parent's Responsibility, 5-4*
- CONSUMER CREDIT PROTECTION ACT (CCPA) LIMITS, 5-5
  - *Background, 5-5*
  - *Applicability, 5-6*
  - *Amount of CCPA Limits, 5-7*
  - *The Potential for Manipulating the CCPA Limits, 5-8*
  - *Health Care Coverage for the Child When the Withholding Limits are Breached, 5-8*
- PRIORITY OF WITHHOLDING, 5-9

Theme

Because circumstances of families change, orders often seem out of date before their provisions are even put into place. Sometimes orders have to be changed, but often the issues can be solved by having reasonable and realistic enforcement rules that help IV-D agencies and employers apply the provisions of award over time even though individual fact patterns have changed. This chapter includes recommendations for two of the most difficult enforcement issues—the Consumer Credit Protection Act limitation on wage garnishment and the Priority of Withholding—as well as recommendations for other enforcement issues.

Enforcement of Health Care Provisions of Child Support Orders

Enforcing Orders to Provide Family Health Coverage

The Working Group recommends that decision makers take a number of steps when ordering health coverage for children: (1) consider the private family health coverage that is available to both parents; (2) order the coverage that best meets the child's needs; (3) allocate the costs of health care premiums between the parents; and (4) determine how deductibles, co-payments, and other uninsured health care costs will be shared between the parents. In cases where neither parent has access to reasonable private coverage, the Working Group's decision matrix recommends that children should be enrolled in publicly-subsidized programs.[3]

☞ See CHAPTER 3, The Decision "Matrix" page 3-17.

These changes in policy—looking to the custodial parent for coverage and directing the family to publicly-subsidized programs where the "available" insurance is not accessible or affordable—will result in more custodial parents providing such coverage. It will also require decision makers to order noncustodial parents to make payments to offset the custodial parent's provision of the coverage. Whether this amount is incorporated into the current child support obligation or delineated as an additional sum in the order, it is likely to be collected through income withholding.[4] The reasons for this include ease of administering the income withholding process, particularly with an increasingly automated child support enforcement system.[5]

> *"I'd like to see ... the effective administration of child support. No matter what administrative or court-ordered kind of thing, they [the children] benefit no matter what the structure of their family is, no matter where the parents are or who the kid lives with. Our mission is to get coverage for kids."*
>
> **~Rita Zeidner, Manger of Government Relations, American Payroll Association**

The Working Group recognizes that there are additional problems that both IV-D agencies and the private bar struggle with while seeking to secure and enforce medical child support for all children. One issue is how to secure compliance from an individual who has no family health care coverage and who breaches an order for cash support entered either to cover the cost incurred by the other parent or to meet an obligation for unreimbursed medical expenses for the child. While no new remedies are proposed by the Working Group, it is anticipated that implementation of other recommendations in this Report will enable courts or administrative hearing agencies to adjudicate contempt actions in a timely and effective manner. Similarly, the broad enforcement tools granted to IV-D agencies by PRWORA will allow for the expeditious collection of a child support debt created by breach of the medical support provisions of a child support order.

In a similar vein, the Working Group recognizes that implementation of its guidelines recommendations, set out in CHAPTER 3, will be applied to requests by either party to modify an existing support order—including modifications requested primarily to add a medical support provision. States will have to incorporate these guidelines for medical support into laws and procedures related to the standard for modifying a support order (i.e., whether there must be a threshold dollar or percentage change in the cash support amount before a request for modification is granted); and, for IV-D agencies, how its statutory obligation to "review and adjust" child support orders is accomplished.[6]

Enforcement Issues in Interstate Child Support Cases

In approximately 25 to 30 percent of all child support-eligible families, the noncustodial parent lives in a different State from the child.[7] Interstate child support cases are generally viewed as the most difficult child support cases to enforce, in part because of the difficulty of locating a noncustodial parent across State lines.[8] While legal efforts have been made to simplify interstate child support case processing, notably with the Uniform Interstate Family Support Act (UIFSA), it is still safe to say that interstate case processing remains more complex than intrastate case processing.

New Hire Reporting requires employers to provide basic wage information about their newly hired employees.[9] This information has proven vital in locating child support obligors and putting an income withholding order in place with the obligor's new employer to obtain cash child support that is due. A number of States already use their New Hire Reporting procedures to obtain information regarding the availability of medical coverage.

Congress convened the U.S. Commission on Interstate Child Support in 1988. The broad charge of the Commission was to submit a report to Congress with recommendations to improve the interstate establishment and enforcement of child support awards. In its final report to Congress, the Interstate Commission also made a number of recommendations to improve the enforcement of medical support orders. Congress adopted many of these medical support recommendations and included them in OBRA '93.[10]

OBRA
Omnibus Budget Reconciliation Act of 1993

One relevant recommendation enacted in OBRA '93 precludes insurers from denying enrollment of a child because the child does not reside in the insurer's service area.[11] Despite the inclusion of this provision in Federal law, the Working Group learned that there are still many geographical barriers to children obtaining health coverage in both the interstate and intrastate contexts. In part, this problem may exist because some insurers and employers are confused about the scope of §1908 and do not know that they are subject to it.[12] HCFA will issue regulations that will undoubtedly clarify the anti-discrimination provisions.

HCFA
Health Care
Financing
Administration

The Working Group has made a number of recommendations to address geographic barriers to coverage. Geographic barriers can be particularly problematic for a family when only one parent has private family health coverage available and that coverage discriminates against a child because of geography. This situation effectively denies the child private health coverage, and unfairly forces the taxpayer to shoulder the burden of public coverage if the child is enrolled in Medicaid or SCHIP when, in fact, one of the parents has coverage available and should provide it.

Monitoring and Enforcing Custodial Parent's Responsibility

If the Working Group's recommendations are implemented, increasing numbers of *custodial parents* will be ordered to provide health care coverage to their children. Establishing the medical support obligation of the custodial parent will increase the potential for more children being covered by private health insurance, thereby lessening the Medicaid rolls and costs to the State and Federal taxpayers. If the custodial parents do not comply with medical support orders, the IV-D agency will have to enforce them. This raises both ethical and resource issues for the IV-D program.

A threshold concern is the ethical problem, resulting from the IV-D agency's need to enforce a medical support order against the custodial parent. The Working Group examined various States' practices and determined that the vast majority of States do not consider the custodial parent to be their client. Statutes in these States expressly provide that the IV-D agency represents the interests of the State, rather than those of any individual parent or child.[13] Since the State is interested in ensuring that children have health care coverage, the Working Group concluded that enforcing medical support orders against custodial parents would not create an unethical situation or conflict for IV-D child support attorneys, as long as custodial parents clearly understand that the agency represents the State, rather than the parent.

However, the Working Group concluded that IV-D agencies need to make it absolutely clear to custodial parents that they might be ordered to provide their children's health care coverage. Child support agencies should tell custodial parents that if they do not comply with an order to provide coverage, the State will enforce the order against them.

The Working Group also considered the difficulty that a IV-D agency might encounter in enforcing a medical child support award against a custodial parent, when the reason that the parent was not providing coverage was that the noncustodial parent was not contributing to the cost of coverage as ordered. In that case, the Working group concluded that the State should not enforce the order against the custodial parent. States currently have to decide when and how to enforce child support orders,[14] and we expect them to exercise this discretion.

Moreover, the Working Group agreed that the child support agency should consider modifying an order if the child loses coverage because the ordered coverage is no longer available or because the noncustodial parent failed to pay the custodial parent the ordered portion of the premium. Until a new order is in place, the State should enroll the child in the Medicaid or SCHIP program if the child qualifies. See Recommendation 44.

Consumer Credit Protection Act (CCPA)[15] Limits

Background

The Federal CCPA limits the percentage of an obligor's disposable income that may be withheld for child support purposes.[16] Under the CCPA, if the obligor supports only one family the maximum amount that may be withheld for child support purposes

Recommendation 44 (Federal Legislation)

When the decision maker requires the custodial parent to provide coverage for the children, the parent should verify that the children have been enrolled within a reasonable time, to be determined by the State. When the child support enforcement agency provides enforcement services, and the children are not enrolled as ordered, the child support enforcement agency should take appropriate steps to enforce the order against the custodial parent. However, any notice that is sent to the parent should ask the custodial parent to contact the child support enforcement agency if she did not provide health care coverage because of some financial difficulty, a change in employment, other change in circumstances, and/or the noncustodial parent's failure to comply with an order that required him/her to pay a portion of the premium.

is 60 percent of disposable income. If an obligor supports more than one family, the maximum amount that can be withheld is 50 percent. Both of these amounts may be increased by five percent, to 65 percent and 55 percent respectively, if the obligor's child support payments are in arrears for at least twelve weeks.[17]

Applicability

There is some confusion about when the lower withholding ceiling for parents who are supporting multiple families actually applies. Some states apply the lower (50 percent/55 percent) limits only when the obligor is *living with* and contributing to the support of one of his families. Other states use the lower limits when the obligor is *living alone* but has obligations to more than one family. This can lead to inequities in interstate cases.

The legislative history and case law pertaining to this provision of the CCPA suggest that Congress intended the lower CCPA limits to apply only when an obligor is *living with* a family that the obligor is helping to support. The CCPA was amended in 1977 to include the child support withholding limits. Remarks offered by Senator Nunn on the Senate floor when introducing the amendment, as well as language in the conference report of the bill that included the amendment, both suggest that the amendment was intended to protect "second families" from financial ruin. While there is very limited case law that makes reference to the child support withholding limits, what little there is generally assumes that the lower withholding limits apply to noncustodial parents who are supporting a second family in their own household.

Therefore, the Working Group recommends that this interpretation be adopted nationally so that practice on this issue is uniform. Since the Department of Commerce has the authority to clarify this issue, the Working Group asks that the Secretaries of Labor and HHS request the Secretary of Commerce to issue such guidance. See Recommendation 45.

Recommendation 45 (Federal Regulation)

The Secretaries of HHS and DOL should request the Department of Commerce to review the current provisions of the Consumer Credit Protection Act, which specifies limits on wage garnishment for family support payments, 15 U.S.C. §167(b)(2)(A) and (B). The Department should clarify whether the lower wage garnishment applies only to individuals who have an order to support a spouse or one or more children outside of their households and are also supporting a spouse and/or child within their household.

Amount of CCPA Limits

The Working Group recognized that under current child support guidelines some noncustodial parents pay a substantial percentage of their income in a combination of cash and medical support. Lower income noncustodial parents are left with too little income to live on. Even at higher income levels, parents who pay more than half of their income in child support may quit their jobs and/or enter the underground economy. Then the children receive neither cash support nor family health coverage.

The CCPA sets the upper limits on the amount that can be withheld. States can set lower withholding limits and at least 18 states have done so.[18] Moreover, decision makers may use their discretion to set even lower limits in appropriate cases. For example, Washington State has established a withholding limit of 50 percent of disposable income. When the obligor owes both current and back support, the obligor can negotiate with the Support Enforcement Officer to collect less than 50 percent by lowering the amount collected on arrears if the 50 percent standard would leave the obligor with too little income for self support. In exchange for this break however, the Washington obligor has to waive the statute of limitations on arrearages. The result is that less will be collected each month but eventually everything will be paid off. See Recommendation 46.

One way to address this problem is to reduce the number of cases in which a noncustodial parent is asked to provide private health care coverage that is very costly relative to the noncustodial parent's income. The Working Group believes that its definition of "reasonable cost" will have this result and thereby reduce the number of cases in which excessive withholding is a problem. Nonetheless, even with this change, there will be cases when application of State or Federal wage withholding limits may result in excessive withholding—for example, when the parent has accumulated significant arrears or when the parent has multiple support obligations.

☞ See Recommendation 9 through Recommendation 11 in CHAPTER 3 for definition of "reasonable cost."

For this reason, the Working Group considered whether Federal law should be amended to set lower limits. After careful

Recommendation 46 (Best Practice)

The current Federal wage-withholding limits should be maintained, but the Federal OCSE should advise the States that they can set lower limits, as long as they are not so low that they make it impossible to order the parent to provide health care coverage, in addition to child support, when it is available at reasonable cost.

consideration, it was decided that the current statute should be maintained since it provides a ceiling on withholding while allowing States to set lower limits if they think this is appropriate. The Working Group noted that many States have done this and more might consider doing so if they were more aware of their options.

Therefore, the Working Group recommends that OCSE remind States that they have this choice. However, the Working Group also suggests that States be advised that it would be inappropriate to set a level so low that noncustodial parents would rarely be contributing toward the cost of their children's health care coverage.

The Potential for Manipulating the CCPA Limits

The CCPA limit is calculated on disposable income. Noncustodial parents can manipulate their disposable income in order to avoid paying the full amount of their cash and medical support obligations. To prevent this from occurring, the Working Group recommends that in any IV-D case where the withholding limits are reached, the agency should examine how the obligor's disposable income was calculated to determine whether it is being manipulated to avoid meeting a child support obligation.[19]

See Recommendation 47.

Health Care Coverage for the Child When the Withholding Limits are Breached

The Working Group has recommended a definition of "reasonable cost" that takes into account the premium required to obtain health care coverage relative to the income of the parent who is to provide that coverage. The Working Group has also recommended that when the cost of available coverage is not reasonable under that definition, the tribunal should order the custodial parent to enroll the children in Medicaid or SCHIP if they are eligible for either of those programs. The noncustodial parent might also be asked to help contribute toward the cost of Medicaid/SCHIP coverage. This ensures coverage for children within their parent's ability to pay for such coverage.

☞ See Recommendation 9 through Recommendation 11 in CHAPTER 3 for definition of "reasonable cost."

The Working Group believes that the

Recommendation 47 (Best Practice)

In any case where the amount of the parent's current child support payments exceeds Federal wage withholding limits, the decision maker should examine the calculation of the noncustodial parent's disposable income to determine whether the parent is reducing their disposable income through excessive withholding or other reductions in gross income that are not contemplated by the Consumer Credit Protection Act (CCPA).

rationale which led to these decisions would lead to a similar result when an employee's child support obligation(s) exceed withholding limits. If the combination of cash and medical support that the obligor is required to pay would breach the withholding limits, then the medical child support obligation should be modified, the child should be moved to appropriate publicly-subsidized coverage, and a noncustodial parent contribution toward the cost of that coverage that can be met within the withholding limits should be established.

See Recommendation 48.

Priority of Withholding

A typical child support order includes three elements: (1) current support, (2) medical support, and (3) arrears. If the *custodial parent is* to provide health care coverage, the amount that the noncustodial parent will contribute to the cost of obtaining that coverage will be included in the amount designated as current support. In that case, the order will have one element (current support) or possibly two (if arrears are owed). If an employer receives a withholding order that requires the payment of a sum in excess of the withholding limits, the employer will withhold the maximum amount possible up to those limits and forward the money to the State Disbursement Unit (SDU) for disbursement. Under Federal law, the SDU must first pay current child support and medical support out of the amount withheld, then pay arrears.[20]

If the *noncustodial parent* is providing health care coverage, the situation is different. In that case, the order will designate a current cash support amount and arrears (if applicable) and require that sum to be sent to the SDU for disbursement. It will also order the employer to withhold the amount necessary to pay any premium associated with the children's health care coverage. Most employers have plan benefit administrators who determine the employee contribution for the health care premium and forward the information to payroll managers, who then withhold the amounts from employee's salaries. Both benefits are normally not withheld simultaneously by one entity.

Recommendation 48 (Best Practice)

If the cost of providing private health care coverage increases a parent's child support obligation so that the amount exceeds Federal wage-withholding limits, the decision maker should have the authority to direct the custodial parent to apply for the Medicaid or SCHIP. If the child is found eligible, the decision maker may require the noncustodial parent to contribute toward the cost of coverage consistent with Recommendation 19

> *"[T]here should always be discretion to permit ... the custodial parent to indicate that they prefer some other priority order for the distribution of funds that are withheld."*
>
> **~Cristina Firvida, Counsel, National Women's Law Center**

The health care administrator cannot know whether the employee's cash and medical support obligations will exceed withholding limits. Even when the problem is identified, there is currently no uniform Federal guidance to employers about how to handle the situation. Employers and plan administrators would like direction about whether to give priority to cash support or to health care premiums. Such guidance would allow them to treat all of their employees equally and would also facilitate decisionmaking in interstate cases where there may be conflicting State laws. For this very reason, Congress asked the Working Group to examine the issue of priority of payment when an obligor lacks sufficient income to pay both the cash child support and medical support premiums without violating the withholding limits.[21]

In addressing this issue, the Working Group faced a fundamental dilemma: to give priority to cash support at the expense of a health care premium means that children could lose private health care coverage. But giving priority to health care premiums over cash support may mean that the children's other basic needs, such as rent payments, cannot be met. Neither is a desirable outcome.

One way to address this problem is to reduce the number of cases in which a noncustodial parent is asked to provide health care coverage that is expensive relative to disposable income. The Working Group's recommendation regarding "reasonable cost" should have this result and should help to reduce the number of cases in which this priority issue arises.

Even with this change, however, there will be instances where the withholding limits would have to be breached in order to satisfy all of the ordered obligations. Employers and plan administrators will still need guidance about how to stay within the withholding limits, especially in a situation where an obligor has support orders for multiple families. In that situation, even if the individual orders are lower than the withholding limits, they may collectively breach those limits.

To develop guidance in this area, the Working Group looked first at State practice. It found that while most States do not provide explicit guidance in their child support guidelines or State IV-D plans on how to handle this situation,[22] a few States do. For example, in California, cash support is given first priority, payments toward family health coverage premiums are second.[23] In New Jersey, when there is insufficient income to pay cash support and family health coverage premiums without exceeding the obligor's net income "reserves,"[24] the State has specified that child support is paid first.

The Working Group also examined this issue in light of the traditional primary mission of the child support enforcement program, which is to collect cash child support. Moreover, the custodial parent is the one who must meet the children's immediate needs. Reducing or eliminating cash support by giving priority to health care premiums may make it impossible for the custodial parent to do so. Finally, while the children may lose private coverage if premiums are not paid, it may be possible for them to obtain public coverage through Medicaid, SCHIP, or some other program. Since these alternatives are increasingly available, cash support for other needs is primary.

For all of these reasons, the Working Group recommends that when priority of payment becomes an issue, the general rule should be that cash support is withheld first, then private health care premiums, then arrears. Because the Working Group wanted to give flexibility to judges and administrative agencies in varying this priority of withholding when it would be in child's best interest to do so—when for example, a child has such large medical costs that the value of the family health coverage premium outweighs any cash support the child might receive—the Working Group's recommendation also allows a deviation from the general rule on a case-by-case basis regarding priority of payment.

Finally, the Working Group wishes to emphasize that this recommendation applies to the situation in which the trade-off is between cash support, *private* health care premiums, and arrears. In cases where the issue is whether to pay cash support, noncustodial parent contribution toward

Recommendation 49 (Federal Regulation)

A Federal policy on the priority of allocation by employers of funds collected through wage withholding should be promulgated. Employers should first attribute withheld funds to current cash support (alimony and child support), then to health care premiums and other current medical support, then to arrears (cash or medical) and then to other obligations. Decision makers should have the flexibility under State law to deviate on a case-by-case basis and provide that health care premiums will be paid first when that is in the best interest of the child.

Medicaid/SCHIP and arrears, priority should be given to current cash support and arrears owed to the family before any monies are used to pay noncustodial parent contributions toward publicly subsidized coverage. See Recommendation 49.

In this chapter, we looked at the hard questions that face the child support enforcement agency and employers in enforcing medical support provisions in child support orders. Upon careful review of the many obstacles, the Working Group has recommended statutory, regulatory, and implementation practices to improve the health care coverage of America's children.

Endnotes

[1] 42 U.S.C. §652(f) (1999).

[2] Pub. L. 105-200, Title IV, §401(a)(5), 112 Stat. 659 (1998), codified at 42 U.S.C. §658a (note) (1999).

[3] See Chapter 3.

[4] See United States House of Representatives Committee of Ways and Means, "Green Book" (1998), 571.

[5] The Interstate Commission noted the use of income withholding in the medical support context in its report "Blueprint for Reform" (1993), 140.

[6] Pub. L. 100-485 (Family Support Act of 1998).

[7] See, for example, Lyon, Matthew. "Characteristics of Families Using Title IV-D Services in 1995." U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (May 1999), 4; U.S. Commission on Interstate Child Support, "Supporting Our Children: A Blueprint for Reform," xii; Wheaton, Laura. "Noncustodial Fathers: To What Extent do They Have Access to Health Care Coverage?" The Urban Institute (2000), 15.

[8] The New Hire Reporting program should greatly improve locating noncustodial parents in the interstate context.

[9] See Chapter 3.

[10] Pub. L. 103-66, Title IV, Subtitle D, §609(a) (1993), codified at 29 U.S.C. §1169 (1999). The Interstate Commission recommended, and Congress subsequently adopted in OBRA 93, a whole series of anti-discrimination provisions for insurers and employers, prohibiting them from failing to enroll dependents of employees because, for example, the child was born out of wedlock, not claimed as a dependent on the employee's income tax return, or not residing with the employee or in the insurer's service area.

[11] Section 1908(a) of the Social Security Act, codified at 42 U.S.C. §1396g (1999).

[12] For example, many insurers limit their provision of coverage within a city metropolitan area, beyond which, even if within the same State, a child would not be covered except under an "emergency exception."

[13] A 1993 Child Support Enforcement analysis indicates that 26 states have provisions that make it clear that the agency represents the State, not the parent(s) in IV-D cases. (See memo provided to subcommittee members by Susan Notar. Staff updated this memo for the Working Group.) As a result of that update, it appears that, as of now, in thirty States, the IV-D agency represents only the State. OCSE Information Memorandum (OCSE-IM-93-03) on the role of attorneys in the IV-D child support agency is available from OCSE.

[14] Federal guidance makes it clear that States (not parents) decide when and how to enforce an order (45 CFR §303.6). This flexibility could certainly be used in deciding whether to enforce a medical support order against a custodial parent.

[15] Pub. L. 90-321; 82 Stat. 146 (1962), codified at 15 U.S.C. §1601 et seq. (1999).

[16] 15 U.S.C. §1673(b) (1999).

[17] *Id.*

[18] Alaska, Arizona, California, Idaho. Iowa, Louisiana, Maine, Missouri, Nevada, New Mexico, North Dakota, Oklahoma, Texas, and Washington limit withholding to 50 percent of disposable income. South Dakota limits withholding to 50 percent of net income. Connecticut, New York, and Tennessee vary the limits with income and number of orders.

[19] Federal case law clearly provides that the CCPA limits do not apply to tax refunds.

However, this does not prevent the custodial parent's family from suffering hardship if monthly support payments are reduced because of excessive withholding by the noncustodial parent.

[20] 42 U.S.C. §654, 657 and 45 C.F.R. 302.51 (1999).

[21] 42 U.S.C. §658a note (1999). The Federal Office of Child Support Enforcement has allowed States to set their own policy in this area as long as it was consistent with Federal law and policy.

[22] The States that do address the priority issue in their guidelines are: California, Missouri, New Jersey, and Washington.

[23] Except in the Sacramento County IV-D Kids program—when a child is placed on the IV-D Kids plan, family health coverage is paid first, then cash support.

[24] Defined as below 105 percent of the poverty line for one person after paying child support, or the custodial parent's net income below 200 percent of the poverty line for the number of persons in the primary household.

CHAPTER 6. Moving Towards Seamless Coverage: Improving Coordination and Communication Among Private and Public Health Care Coverage

Private employment-related group plans provide health care coverage for a majority of America's children, yet rarely is such coverage continuous. Frequent job changes make insurance coverage uncertain. Many parents are part-time or seasonal workers, who may have erratic coverage or difficulty in meeting eligibility requirements for employer-based coverage. Even when employment is stable, employers may change insurance plans.

Where the noncustodial parent is obligated to provide private coverage, such changes often create more uncertainty. Often, neither the custodial parent nor the child support agency responsible for enforcing the order learn of the change in employment and the need to apply for new public or private coverage until after the child's insurance has lapsed. And, if a child's private health care

CHAPTER 6 AT A GLANCE

OUTREACH FOR MEDICAID AND THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM, 6-3
SCHIP BARRIERS, 6-4
  Crowd-Out Policies, 6-4
  Access to Health Care Coverage, 6-6
SCHIP/MEDICAID/IV-D INFORMATION EXCHANGE, 6-8
INCREASED EFFICIENCY IN THE COORDINATION OF PUBLIC AND PRIVATE COVERAGE, 6-12
  Automated Data Matches with Private Insurers, 6-13
  Repeal Mandatory Pay and Chase, 6-14
ERISA ISSUES RELATED TO CHILDREN COVERED UNDER QMCSOS, 6-17
  HIPAA and COBRA, 6-17
  Circumstances Under Which Group Health Plans May Impose Preexisting Condition Exclusions, 6-21
  Coordination of ERISA Medical Child Support Provisions with Social Security Act Medical Child Support Provisions, 6-22

Theme

Under the current system it is very easy for children to have periods in which no health care coverage is available. The extent to which this happens could be decreased by building feedback loops into the information flow between IV-D agencies and the public health care providers, Medicaid and SCHIP. Additionally, IV-D, Medicaid, and SCHIP agencies need to be working from a common understanding when obtaining private or public health care coverage or both are in the best interest of the child. IV-D should work with Medicaid and SCHIP, as well as with private insurers, to assure that the child is enrolled in appropriate health care coverage.

coverage lapses, they are likely to be uninsured for several months, as they may be subject to waiting periods before they are eligible for new coverage through the employer or through an SCHIP. Furthermore, replacement coverage may not pay to treat pre-existing conditions.

SCHIP
State Child Health Insurance Program

Similarly, as the child's private insurance status or family income changes, their eligibility for SCHIP or Medicaid may change. Children who do not successfully transition to private or public insurance when the changes occur will be uninsured or underinsured.

Recognizing that children need *seamless* health care coverage, Congress charged the Working Group to report on "appropriate procedures for coordinating the provision, enforcement, and transition of health care coverage under the State programs operated pursuant to part D of Title IV of the Social Security Act and titles XIX and XXI of such Act."[1] Early on, the Working Group realized that Medicaid and SCHIP need to be included in the medical child support decision matrix, along with private insurance, in order to maximize a child's access to quality health care coverage. Coordination among these programs and with private insurers is essential.

A significant number of children who receive IV-D child support services qualify for Medicaid and SCHIP coverage. State officials are working with Federal agencies to reach as many potentially eligible, uninsured children as possible through amendments to State Plans. IV-D agencies can and should play a major role in these efforts. Adequate planning, coordination, and collaboration between IV-D, Medicaid, SCHIP and other appropriate public and private agencies are essential to ensure that every child who is eligible for child support services has comprehensive health care coverage.

> *"[W]e were all somewhat taken aback by and very concerned ... that there does not seem, at the current time, to be a good interface between Medicaid, CHIP, and IV-D and that many of the problems that we've identified really go to that lack of interface."*
> **~Sallie H. Hunt, Commissioner, Bureau of Child Support Enforcement, HHR, West Virginia**

See description of The National Child Support Enforcement (IV-D) Program, page 1-6.

Public agencies, such as IV-D, Medicaid and SCHIP and private employers and insurers must coordinate their efforts in order to secure the best possible coverage for children and to minimize disruptions in coverage when children move between private coverage and public coverage.

Outreach for Medicaid and the State Children's Health Insurance Program

In order to ensure that the maximum possible number of children has continuous health care coverage, it is important to enroll children in appropriate coverage as quickly as possible. Children who do not have reasonable access to appropriate private coverage should be enrolled in public coverage if eligible.

The Working Group believes that linking child support programs with Medicaid and SCHIP could make it possible to reach more eligible families. Indeed, a letter from OCSE's Deputy Commissioner to State IV-D Directors makes this very point. IV-D agencies "have immediate access to necessary information regarding the children's health coverage and the parents' income, employment, and other financial information. The agencies could provide an invaluable service by identifying potentially eligible recipients and making SCHIP information and applications available to them." Some State IV-D programs are already trying to inform working parents about the Medicaid and SCHIP programs.

Child support agencies can identify eligible uninsured children and streamline enrollment in the SCHIP and Medicaid programs.[2] The Working Group believes that IV-D agencies should be added to the list of qualified agencies permitted to make presumptive Medicaid eligibility determinations for children, and recommends that the Medicaid statute be amended accordingly.[3] This could expedite enrollment of eligible children in the Medicaid and SCHIP programs. Once the child support agency determines that private coverage is not an option, the IV-D agency could use the income information it has gathered to calculate the amount of cash support under the guidelines and make a preliminary determination that the child is Medicaid or SCHIP eligible, if the State has chosen to provide presumptive coverage for children under Medicaid or SCHIP. The child could then be enrolled as presumptively eligible and coverage could begin immediately. While Congress should not require States to use their IV-D programs to determine a child's presumptive eligibility for Medicaid or SCHIP, they should be strongly encouraged to do so. If they choose not to, states should adopt other methods to facilitate enrollment in the Medicaid and SCHIP programs. See Recommendation 17 and Recommendation 18, CHAPTER 3.

One of the barriers to enrollment in Medicaid and SCHIP is the burdensome application and enrollment process. Some States have applications over 20 pages long, posing an often insurmountable challenge for families.

A key to successfully reaching and enrolling uninsured children in SCHIP and Medicaid is a simple application and enrollment process. Federal requirements for application and enrollment in Medicaid and SCHIP provide broad flexibility to States in designing their applications and developing their enrollment process. Many States have simplified the complicated application forms and enrollment processes, as well as allocated more resources to outreach activities. Currently, States are trying to encourage enrollment through such methods as creating joint SCHIP/Medicaid applications, reducing and simplifying the application forms, providing mail-in applications, and developing a follow-up process for families who do not complete the application.

HCFA has developed a model joint application for SCHIP/Medicaid for children (see APPENDIX H: Model Joint Medicaid/SCHIP Application Form, page A-59).[4] States can allow individuals to use this form to apply for both programs and the information can be sufficient for determining which program a child is eligible for. The simplified form asks only for necessary information and allows for application by mail. The Working Group supports HCFA's efforts to streamline and simplify the application process, and encourages all States to adopt a joint Medicaid/SCHIP application. See Recommendation 50.

HCFA
Health Care Financing Administration

SCHIP Barriers

SCHIP does not always offer an adequate safety net for all child support-eligible children. There are specific eligibility criteria in Title XXI that create barriers to obtaining continuous coverage for children. These barriers include SCHIP crowd-out policies and denial of SCHIP eligibility based on access to private coverage.

Crowd-Out Policies

While most children[5] who have private health care coverage also can be eligible for Medicaid, children with other coverage are generally not eligible for SCHIP. Whenever a State implements Title XXI through a Medicaid expansion, the Medicaid program rules apply and children may be enrolled in private health care coverage as well as in the Medicaid expansion program. On the other hand, when a State implements Title XXI

Recommendation 50 (Federal Guidance)

HCFA should continue to encourage joint Medicaid/SCHIP applications to streamline the application process.

through a separate SCHIP, different rules apply, which are sometimes problematic.

One of the fundamental principles of Title XXI is that SCHIP coverage should not supplant existing public or private coverage (commonly referred to as "crowd-out"). Title XXI contains provisions specifically designed to ensure that States use SCHIP funds to provide coverage only to uninsured children. Specifically, Title XXI requires States to ensure that coverage provided under SCHIP does not substitute for coverage under either private group health plans or Medicaid.

According to HCFA, the potential for crowd-out exists because SCHIP coverage costs less and provides better coverage than coverage purchased by some individuals and employers. Specifically, employers who make contributions to coverage for dependents of lower-wage employees could potentially save money if they reduce or eliminate their contributions for such coverage and encourage their employees to enroll their children in SCHIP. At the same time, families that make significant contributions towards dependent group health coverage could have an incentive to drop that coverage and enroll their children in SCHIP if the benefits would be comparable or better and their out-of-pocket costs would be reduced.

In cases where insurance coverage is provided directly through SCHIP or Medicaid, States are required to establish reasonable procedures to ensure that coverage provided under the SCHIP plan does not substitute for coverage under group health plans. In cases where SCHIP funds are used to subsidize coverage provided through employer-sponsored group health plans, States are required to implement specific precautions, including imposing a waiting period. Many States impose a waiting period that ranges from 3 to 12 months, with certain exceptions. An otherwise SCHIP-eligible child who has just lost private coverage must wait until the end of this waiting period before he may enroll in SCHIP coverage.

The waiting period can be particularly troublesome when the child's health insurance is to be provided or paid for by a noncustodial parent who often may live far away from the child, may not have good patterns of communication with the custodial parent, may have limited income, and may have a history of frequent and sudden job change. While many of these problems affect both intact and non-intact families, in families with a noncustodial parent they are exacerbated by potential lack of communication between the custodial and noncustodial parent. The custodial parent may not even know of the noncustodial parent's oft-changing employment status, and therefore be unaware of when the children have coverage and when they do not.

Children may also lose private coverage when the custodial parent is providing coverage and the noncustodial parent is ordered to contribute toward the cost of the coverage, but fails to do so. The custodial parent may have no control over the loss of private coverage and in these cases there is no deliberate effort to move the child from private coverage to the SCHIP program. The Working Group believes that the waiting period does not serve a valid public policy purpose here and therefore ought not to be imposed in such cases.

HCFA has already issued proposed SCHIP regulations that would explicitly allow exceptions to the minimum waiting period if the prior coverage was involuntarily terminated by the employer in a State that has a policy of subsidizing employer-sponsored group health plans.[6] Many States already provide exceptions to the requirement that the child be uninsured for a certain period of time. For example, Connecticut, Iowa, Kentucky, New Hampshire, and North Carolina have developed a broad range [illegible] exceptions to their waiting period in order to accommodate involuntary termination of private coverage.

Because of the unique situation of child support-eligible children, the Working Group recommends that every State exempt children who lose health care coverage pursuant to a medical support order from the requirement that children be uninsured for a certain period of time before becoming eligible for SCHIP. The Working Group anticipates that HCFA will address the issue of crowd-out in the SCHIP final rule.

See Recommendation 51.

Access to Health Care Coverage

The Working Group was particularly concerned about the problems created when the decision maker orders a child to be placed in health care coverage that is not geographically accessible to the child. Recognizing the futility of enrolling a child

Recommendation 51 (Federal Guidance)

HCFA should provide guidance to States to make children who lose health care coverage pursuant to a medical support order an exception to the SCHIP "crowd out" provision by eliminating the waiting period for these children. In particular, guidance would include eliminating the waiting period when the custodial parent loses court- or agency-ordered dependent health coverage due to the noncustodial parent's failure to comply with an obligation to reimburse the custodial parent for the premiums.

in such coverage, some parents ignore this aspect of the order. In other cases, the obligated parent follows the order and enrolls the child, making the child ineligible to participate in SCHIP, although, for all practical purposes the child is uninsured.[7]

Implementing the Working Group's recommendation on the definition of "accessible" should prevent this from happening in the future (see Recommendation 8, page 3-10). However, a substantial number of existing orders will continue to create problems for children who need SCHIP coverage. The Working Group believes HCFA should address this problem by making it clear to states that a child who is enrolled in inaccessible coverage should be categorized as "uninsured" for SCHIP purposes. We note that a discussion of this issue, consistent with this recommendation, is included in the preamble to the proposed SCHIP regulations.[8] 🗎 See Recommendation 52.

In addition, Title XXI allows States the option to preclude enrollment in SCHIP to an otherwise SCHIP-eligible child whenever that child has access to other creditable health insurance but is not enrolled in that coverage. A few States have elected this option. For example, in Michigan children that have employer-sponsored coverage available will not be enrolled in the State's CHIP. This restriction creates another barrier to obtaining stable, continuous coverage for children, particularly if parents themselves are cycling on and off employer-sponsored insurance due to employment patterns, making it difficult to determine if and when private coverage is available to the child, and preventing the possibility of continuous private or public coverage for the child. To facilitate the enrollment of children in the most appropriate coverage (that is, accessible, comprehensive, and

> *"[T]he CHIP program in our State [Alabama] also has a comprehensive package for these kids, and I guess my concern is that children who have other coverage, from a noncustodial parent or whomever, are excluded from CHIP, yet the plan that's causing them to be excluded doesn't provide a lot of the care that they need."*
>
> **-Kay Keeshan, Director, Third Party Liability Division, Alabama Medicaid Agency**

Recommendation 52 (Federal Regulation)

HCFA should issue SCHIP regulations that allow a child to be eligible for SCHIP if the child is enrolled in a group health plan but does not have reasonable access to care under that plan.

affordable coverage, as defined in Recommendation 8), the Working Group recommends that HCFA encourage States to allow IV-D eligible children to enroll in SCHIP when private coverage is available yet not appropriate and they are otherwise eligible [illegible] SCHIP. 📄 See Recommendation 53.

SCHIP/Medicaid/IV-D Information Exchange

In order to remove significant barriers to medical support enforcement, States must develop efficient and effective mechanisms for communication and coordination among the IV-D, Medicaid, SCHIP and other programs that provide health care coverage for low income children. This will improve the child's chance of being promptly enrolled in appropriate health care coverage with minimal or no delays or disruptions.

Clearly, the enrollment of IV-D children in public rather than private health care coverage raises many complex organizational and procedural concerns. That is why the Working Group recommends that HHS convene an interdisciplinary task force that represents all of the State and Federal agencies involved in medical support, as well as other appropriate stakeholders. This task force would identify issues that need to be addressed in order to effectively implement the Working Group's recommendations concerning the enrollment of IV-D children in public insurance, and propose solutions to the identified problems.

While the Working Group was not in a position to identify all of the potential issues that might need to be addressed, it did identify three areas that the HHS task force should address.

❶ Notification Systems

First, the task force should explore ways in which the public programs would benefit from the development of a notification system or a standardized notice to transmit information between the courts, the IV-D program, and the Medicaid and SCHIP agencies. Its possible purposes include:

- **Enabling the decision maker to notify the child support enforcement agency**

📄 **Recommendation 53 (Federal Guidance)**

HCFA should provide guidance to States that IV-D-eligible children are also eligible to participate in SCHIP if private health care coverage is available to them but they are not enrolled in such coverage because the services available through that coverage are not appropriate—that is, they are not accessible, comprehensive, or affordable as those terms are defined in *Recommendation 8.*

that public coverage has been ordered and whether the noncustodial parent has been ordered to contribute to the cost of such coverage.

- Making it possible for the child support enforcement agency to inform the Medicaid or SCHIP agency that a decision maker has ordered that the children be enrolled in publicly financed health care programs and, if applicable, order the parent(s) to contribute to the cost of such coverage.
- Making it possible for the Medicaid or SCHIP agency to inform the child support enforcement agency that a child has not been enrolled as ordered, or that a custodial parent has removed the child from the program or has failed to pay any applicable premiums.
- Enabling the courts and agencies to notify one another when a change has occurred. Such changes might include moving the child from Medicaid to SCHIP or vice versa, enrolling the child in private coverage, cessation of the child's eligibility for Medicaid/SCHIP coverage, and termination of the State child support enforcement agency's responsibility to enforce the order.

❷ Standardized System

Second, the Working Group suggests that the task force should consider whether each State should create a child support/Medicaid/SCHIP database to facilitate a standardized system for exchanging information.

SCHIP and Medicaid programs should be able to determine whether applicants or beneficiaries are enrolled in private health coverage that is enforced through the child support enforcement program. Child support enforcement agencies should, similarly, be able to determine immediately whether children who are receiving IV-D services are receiving or have applied for Medicaid or SCHIP.

Several members of the Working Group met with an Automation Focus Group, comprised of experts from the systems staffs of several States and OCSE. The Automation Focus Group thought that the modifications necessary to enable automated data exchanges between IV-D, SCHIP, and Medicaid would be complicated, costly, and time consuming. Therefore, this idea requires the careful study and consideration of the proposed HHS task force.

❸ Administrative Simplification

The task force should recommend further ways to improve the ease with which the child support enforcement system, Medicaid, and SCHIP interact and share information as needed. 🗎 See Recommendation 54.

This task force should also work with the Courts regarding enrollment of child support-eligible children in Medicaid and SCHIP (see Recommendation 26, page 3-34).

While coordination between Medicaid and IV-D agencies can and must be deepened, these two agencies do have an evolving history of communication, especially around the issues of cooperation and third party liability. The cooperation requirement placed on Medicaid applicants requires them to cooperate with efforts to establish paternity and pursue medical support in order to secure Medicaid coverage for themselves.[9] In previous recommendations, the Working Group has sought to refocus and enhance this partnership in the interest of those children who benefit, or could benefit, from both programs.

However, SCHIP and IV-D agencies do not have the same linkages. Because SCHIP programs not financed through Medicaid expansion funds are not available to insured children, there is no cause for any third party liability action. There is no federally-mandated cooperation requirement for SCHIP applicants.

The Working Group discussed and rejected the option of adding a child support cooperation requirement to the SCHIP program. Members considered whether a cooperation requirement for separate SCHIP programs would help integrate IV-D and SCHIP. Health care program staff and children's advocates shared the concern that existing cooperation requirements discourage custodial parents from enrolling their children in Medicaid. They suggested that putting such a requirement in SCHIP would, similarly, counteract efforts to expand SCHIP coverage to vulnerable children. The Working Group also noted that, although HCFA permits States to impose a State-based child support

Recommendation 54 (Administrative Action)

The Secretary of HHS should convene a Working Group to develop protocols for implementing the recommendations concerning the enrollment of IV-D children in public rather than private health care coverage, particularly in interstate cases. This group should be comprised of staff from OCSE, HCFA, the Office of the Secretary, State Child Support, Medicaid, and SCHIP agencies as well representatives of other appropriate agencies and the courts.

Among the tasks of this Working Group should be: (1) determining the feasibility and advisability of developing and mandating the use of a standard notification system to transmit information between the State courts, child support enforcement agencies, and Medicaid and SCHIP agencies; (2) assessing the feasibility of each State creating a IV-D/Medicaid/SCHIP database to facilitate a standardized system for information exchange; and (3) exploring the possibility of administrative simplification between the IV-D, Medicaid, and SCHIP programs.

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cooperation requirement on families that participate in their separate SCHIP programs, at least one State (Virginia) has selected this option.[10] For all of these reasons, the Working Group concluded that there were strong policy reasons for not creating a Federal child support cooperation requirement in the SCHIP program.

However, the Working Group did see much value, and need, in encouraging IV-D/SCHIP coordination. Enhanced communication will assist in ensuring that children have continuous coverage. Possible areas for information sharing include but are not limited to insurance and other SCHIP eligibility status issues (such as loss of private coverage, newly available employer-based coverage which the SCHIP program or the noncustodial parent may wish to pay the premium for, or loss of income).

In particular, if Recommendation 19 is enacted, noncustodial parents may be required to pay a portion of their child's SCHIP expenses, while the custodial parent pays the SCHIP premium (see page 3-28). If the custodial parent is unable to make the premium payment, the IV-D agency may be able to assist in notifying the noncustodial parent so that he or she has the option of picking up the premium and continuing the child's coverage. In addition, if the custodial parent moves the child off SCHIP, perhaps because of failure to pay the premium, the SCHIP agency must notify the IV-D agency so that the noncustodial parent is not obligated to continue to contribute to the cost of coverage that the child no longer has.

The Working Group encourages SCHIP and IV-D agencies to develop strong relationships and clear avenues of communication in order to ensure that children have every chance at getting and maintaining suitable coverage, with the support of both parents as appropriate.

See Recommendation 55.

Although many uninsured children in the IV-D caseload are eligible for SCHIP or Medicaid, many are not. Even if all of these barriers to SCHIP enrollment are eliminated, SCHIP and Medicaid will not be able to provide coverage for all of the uninsured children who are eligible for child support services. This is because IV-D services are available to every child who is eligible for child support, without regard to the amount

Recommendation 55 (Best Practice)

State child support enforcement and SCHIP agencies should establish effective ways of communicating with each other.

of the family's income or the value of the custodial parent's assets, while Medicaid and SCHIP are available only to families of limited means.[11]

See CHAPTER 8.

Increased Efficiency in the Coordination of Public and Private Coverage

Members of the Working Group believe that children should be enrolled in private coverage, whenever this is appropriate, but realize that parents' situations are fluid. A parent who does not initially have access to private health care coverage through his job may later change jobs, and become eligible for such coverage. Likewise, a parent who has access to group health care coverage may become ineligible for family coverage.

The State child support enforcement agency may learn of this change from a parent or through New Hire Reporting. However, the child support agency may not act on this information until one of the parents requests a triennial review of the support order. Lengthy delays are not in the best interest of the child or the public. When the child support enforcement agency learns that the parent of a child enrolled in Medicaid or SCHIP is eligible for affordable, accessible and comprehensive private insurance, it should move that child to the private coverage as soon as possible, in order to conserve public funds.

> *"Massachusetts' law required that health insurance carriers doing business in the State provide us the information. We just amended our law last week to include employers, because our Medicaid program now is moving in a direction of working more with employers, and we wanted to obtain employer information and that recently passed."*
>
> **~Mary Fontaine, Director, Third Party Division, Benefit Coordination and Recoveries, Medicaid, Massachusetts**

To make sure this happens as quickly as possible, State IV-D agencies should develop protocols for making inquiries when they receive information about potential private coverage. When the noncustodial

Recommendation 56 (Best Practice)

In IV-D cases, when coverage is provided through Medicaid or SCHIP and information provided by the parties or obtained through New Hire Reporting indicates that private dependent health care coverage may now be available, it should be determined whether that coverage is appropriate for the child (as defined in Recommendation 8). If private dependent health care coverage is available and appropriate, the order should be modified as needed and a National Medical Support Notice should be sent to the employer and the child should be enrolled.

parent is currently obligated to cover the child, the child support agency should issue the new NMSN to enroll the child right away. If the order does not include such an obligation, a modification should be sought and then enforced accordingly. 📄 See Recommendation 56.

Automated Data Matches with Private Insurers

State IV-D agencies must be able to make timely and accurate determinations regarding the sources of family health coverage actually and potentially available to parents. The recent development of the proposed NMSN will help make this possible. When implemented, States will use this Notice to identify health coverage available to children, through their noncustodial parent's employment-related health plans. The Notice will also serve as an order to enroll eligible children in the coverage. It will facilitate coordination and communication between State IV-D agencies, parents, employers, and group health plan administrators, and may make it possible to automate the process.

States should take additional steps to identify private health coverage that is actually or potentially available to children. Some State Medicaid agencies conduct automated data matches between their Medicaid eligibility files and lists of participants in private insurance plans. This permits states to identify Medicaid beneficiaries who have private coverage which should pay before Medicaid. Information on noncustodial parents is sometimes matched against the insurer's files, to identify sources of family health coverage for dependents.

For example, Massachusetts's law gives the Medicaid agency authority to conduct data matches with insurance companies doing business in the State.[12] The law grants Medicaid subrogation rights and allows Medicaid to identify family health coverage for Medicaid beneficiaries, including insurance available through noncustodial parents.

Massachusetts has data exchange agreements with every health maintenance organization (5) and at least 25 insurance carriers doing business in the State. At least once a month, Massachusetts matches Medicaid and noncustodial parent files against the insurance data base of policyholders and beneficiaries. No information on health claims or diagnosis is provided.

The match helps the Massachusetts Medicaid agency identify noncustodial parents who have already enrolled their dependents in family health coverage. The information also helps identify noncustodial parents who have family health coverage, but have not enrolled their children. In such cases, the Medicaid agency determines whether a medical support order has been established. If an appropriate order is in place, the Medicaid agency contacts the employer to obtain additional information. If there is no order, the Medicaid agency submits a survey to determine if the child has health care coverage. Once the child is enrolled in private health care coverage, Medicaid becomes the payer of last resort. The primary family health coverage pays first, while Medicaid picks up all co-payments, deductibles, and services not covered by the insurance.

Texas recently passed a law providing for similar computer data matches.[13] It will be beneficial to track the implementation of these laws, in order to identify best practices.

Title IV-D agencies and OCSE should monitor, evaluate and report on current initiatives, where states have developed medical insurance data bases and carry out automated matches with other sources of information about private coverage. Medicaid agencies that maintain these databases should share the information with the IV-D agency. If some states have obtained successful results through these matches, OCSE should hold them up as a best practice. See Recommendation 57.

Repeal Mandatory Pay and Chase

As stated earlier, children who are enrolled in private insurance may also be enrolled in Medicaid, if eligible. When this occurs, Medicaid is always the payer of last resort. Medicaid agencies generally do not pay medical claims when another third party is legally liable for payment. When a third party is liable, Medicaid returns the claim to the provider with instructions to bill the third party. This is referred to as "cost avoidance." There are some exceptions to this rule. For instance, Medicaid agencies are required to pay claims for covered services and seek reimbursement from liable third parties whenever health coverage is provided by a noncustodial parent.

Recommendation 57 (Technical Assistance)

State IV-D agencies, as well as the Federal OCSE, should monitor, evaluate, and report on current State initiatives related to the development of State databases and computer matches with other sources of information about private coverage. Where States have developed these matches, it is essential that the matched information be shared with the IV-D agency. If certain States have obtained successful results through these matches, Child Support Enforcement should hold them up as a best practice. (See Recommendation 5)

Congress imposed this requirement primarily to protect mothers and their dependent children from having to pursue noncustodial parents, employers, or insurers for payment of medical care and services. Insurance carriers of noncustodial parents would often refuse to deal directly with the custodial parent. They would only accept claims that were filed by the policyholder (i.e., noncustodial parent) and would only send reimbursement checks to the policyholder, who often refused to reimburse the appropriate party.

This left Medicaid with the responsibility of trying to recover its cost from the policyholder. This was costly for Medicaid agencies, since it was expensive to pursue reimbursement and they were often unable to recover funds from liable third parties. A Medicaid agency which could save $50 million in cost avoidance might only net $27 million by paying claims and seeking reimbursement. When Medicaid is unable to recover its cost from a liable third party, it circumvents coordination efforts between Medicaid and IV-D by having noncustodial parents pay for health insurance that is not utilized.

OBRA'93
Omnibus Budget Reconciliation Act of 1993

Section 1908 of the Social Security Act (as amended by OBRA 93) provided the relief needed to ensure that payments are made directly to providers, custodial parents, or States. Specifically, §1908 requires insurers to accept claims from the custodial parent (or provider, with the custodial parent's approval) for covered services, without the approval of the policyholder (i.e., noncustodial parent) and to make payment accordingly. The Working Group recommended that Congress amend §1908 to explicitly state that the laws it requires States to pass apply to all children, not only those who are Medicaid-eligible (see Recommendation 63). Based on the §1908 requirements and this recommended legislative change, the Working Group discussed the merits of repealing the mandatory pay and chase requirements.

There was concern that allowing Medicaid to cost avoid claims could result in the provider billing the custodial parent for cost sharing amounts imposed by the noncustodial parent's health plan. The Working Group learned that §1902(a)(25)(C)[14] of the Social Security Act prohibits providers from charging Medicaid beneficiaries (disregarding §1916).[15] In addition, §1902(g) authorizes States to impose a sanction on any provider who seeks to collect payment from a Medicaid beneficiary of up to three times the amount of payment sought. Given these protections, the Working Group agreed that State Medicaid agencies should be allowed to cost avoid claims given the understanding that custodial parents of Medicaid eligible children are informed that providers are not allowed to charge them other than what is provided for in 1916. It is essential that this change be supported by technical assistance and education for health care providers so they do not erroneously bill the custodial parent, and to insurers so they do not incorrectly send the payment to the policyholder instead of the provider.

Some Working Group members expressed concern that eliminating the pay and chase requirement could result in a provider not being paid if a child receives services outside the private plan because those within the plan are not geographically accessible. It was noted that if Recommendation 8 is adopted (see page 3-10), the decision maker will determine whether available health coverage is geographically accessible before establishing an order. This would minimize the risk that children are enrolled in inaccessible coverage. In addition, the Medicaid representatives indicated that providers are generally assured that Medicaid will pay for covered services whenever a third party does not make payment. Individuals located in a region which is outside the service area so that they cannot reasonably avail themselves of services are not generally considered to have a third party resource available to them, therefore, Medicaid would pay.

For these reasons, the Working Group recommends repeal of the mandatory pay and chase requirement whenever health coverage is provided by a noncustodial parent. Of course, Medicaid would still be the payer of last resort. See Recommendation 58.

Another way of reaching this goal may be to look at amending the last clause of §1902(a)(2)(F) so that is reads "...if payment has not been made by such third party within 30 days after the provider of such services has sought to recover payment from such third party;" instead of "...if payment has not been made by such third party within 30 days after such services are furnished;". However, without full legal review by HHS to determine the statutory implications and the potential unintended consequences of such a change, it is difficult to determine what the best solution would be.

Building on the previous discussion, the Working Group considered another

Recommendation 58 (Federal Legislation)

Congress should repeal §1902(a)(25)(F) of the Social Security Act to allow State Medicaid agencies to cost-avoid claims where the third party coverage is derived through a noncustodial parent's obligation to provide medical coverage.

exception to cost avoidance. Section 1902(a)(25)(E) of the Social Security Act requires State Medicaid agencies to pay claims and seek reimbursement from liable third parties for services related to prenatal or preventive pediatric care, including early and periodic screening and diagnostic services provided under 1905(a)(4)(B).

This law was passed because Congress was concerned that the administrative burdens associated with third party liability collection efforts might discourage physicians and other providers of preventive pediatric and prenatal care from participating in the Medicaid program, since beneficiaries who need these services often have difficulty finding quality providers in many communities. Therefore, this law was intended to require States to pay providers and then pursue payment from liable third parties for prenatal and preventive pediatric services.

The Working Group decided not to recommend repeal of this provision since it applies very broadly to non-medical support children.

ERISA Issues Related to Children Covered Under QMCSOs

The Working Group learned of a number of technical barriers to seamless health care coverage for children in the area of ERISA. These issues are discussed in the following sections.

HIPAA and COBRA

The Working Group considered two recommendations intended to clarify how COBRA applies to children enrolled in a group health plan pursuant to a QMCSO. The first related to the term "qualified beneficiary." Although this term is defined to include a beneficiary under a group health plan who is covered under the plan as a dependent of a covered employee, it is not explicit whether a child enrolled pursuant to a QMCSO would be considered a qualified beneficiary.

The proposed recommendation requests clarification that a child covered pursuant to a QMCSO would be considered a qualified beneficiary. Members of the Working Group expressed the view that many plan administrators already treat children enrolled

Recommendation 59 (Federal Guidance)

DOL and HHS should request the IRS to confirm that a child enrolled in a plan pursuant to a QMCSO would be considered a "dependent child" for purposes of the COBRA provisions, and therefore would be considered a "qualified beneficiary." In the event that such a child would not be considered a "qualified beneficiary," COBRA should be amended to provide that such children are qualified beneficiaries.

pursuant to QMCSOs as qualified beneficiaries, but agreed that specific guidance would be helpful to plans, their sponsors and administrators, as well as participants and their beneficiaries, in determining their respective rights and obligations. See Recommendation 59.

The second proposed COBRA-related recommendation relates to the term "qualifying event." If a child covered pursuant to a QMCSO is considered a qualified beneficiary, the child will have a right to elect to continue coverage following the occurrence of a qualifying event (such as termination of the covered employee's employment). Therefore, with respect to these qualifying events, a child who was enrolled pursuant to a QMCSO would be treated similarly to any dependent child of a covered employee.

However, such a child could lose coverage due to the occurrence of certain events that

ERISA[16] background related to COBRA[17] and HIPAA[18]

ERISA has been amended several times to expand the protections available to participants and beneficiaries of group health plans. The Consolidated Omnibus Budget and Reconciliation Act of 1985 (COBRA) contains provisions that permit certain individuals to continue group health coverage that otherwise would be lost under certain circumstances.[19] COBRA's provisions amended ERISA, the Internal Revenue Code and the Public Health Service Act. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) added protections for individuals who have preexisting conditions or who might otherwise suffer discrimination in health coverage based on factors that relate to an individual's health. HIPAA's provisions also amended ERISA, the Internal Revenue Code, and the Public Health Service Act.

COBRA requires group health plans to provide certain covered individuals (called "qualified beneficiaries")[20] an opportunity to elect to continue group health coverage at their own expense for specified periods of time (up to 18 or 36 months).[21] This opportunity arises when coverage would otherwise be lost due to the occurrence of an event (called a "qualifying event") specified in COBRA. The COBRA provisions specifically define the terms "qualified beneficiary"[22] and "qualifying event."[23]

HIPAA places a time limit, up to either 12 or 18 months, on the application of preexisting condition exclusions to newly-enrolled individuals.[24] A preexisting condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within six months prior to enrollment. The 12 or 18 month time limit must be reduced by crediting certain periods of prior health coverage.[25] HIPAA also prohibits group health plans from applying any preexisting condition exclusions against certain newly-enrolled newborns[26] and adopted children.[27] HIPAA additionally requires that group health plans provide special enrollment opportunities for certain newborns and adopted children who become "new" dependents, and for individuals and their dependents who have lost other coverage due to certain events.[28] The provisions of HIPAA do not expressly apply to a child enrolled pursuant to a QMCSO.

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are not experienced by other dependent children. For example, limitations on involuntary withholding from an employee's wages can prevent the payment of the employee's share of any premiums necessary to maintain the child's coverage. Furthermore, the child will lose coverage, when the period covered by the QMCSO expires. It is not clear which, if any, of these would be considered an ERISA "qualifying event." The second proposed recommendation would have requested clarification that the loss of such coverage at any time during the period covered by a QMCSO, or at the expiration of the period covered by a QMCSO, would be considered a qualifying event.

See CCPA limits discussion in CHAPTER 5, starting on page 5-5.

The Working Group agreed that a loss of coverage due to the expiration of the term covered by a QMCSO might constitute a qualifying event, and found that guidance on this issue should be requested. Coverage could be lost at any time during the term covered by a QMCSO, if required employee contributions were not paid. An employee might refuse to contribute, or wage-withholding limitations might prevent the employer from withholding necessary amounts from an employee's wages. Making these a qualifying event for children covered under QMCSOs would provide those children with greater rights than similarly situated dependents living in a covered employee's household, since lapses due to non payment are not deemed ERISA "qualifying events."

However, the Working Group noted that nonpayment of premiums due to the application of withholding limitations would apply uniquely to QMCSO-related coverage. Nevertheless, the Working Group found that implementing such a definition would be burdensome for plan administrators, who would have to determine why premiums were not paid. Accordingly, the Working Group adopted the second recommendation only insofar as it would relate to the loss of coverage at the expiration of the period covered by a QMCSO.

Under HIPAA, group health plans and family health coverage issuers offering group family health coverage are required to offer "special enrollment periods" during which certain individuals may enroll in the plan regardless of any open season restrictions or waiting periods under certain circumstances. There are two types of special enrollment periods which plans must offer: (1) special enrollment periods for individuals losing other coverage, and (2) special enrollment periods for certain new dependents.[29]

HIPAA
Health Insurance Portability and Accountability Act of 1996

If an individual is eligible to enroll in a group health plan but declines enrollment because other coverage has been selected, the individual must be permitted to enroll in the plan if that individual becomes ineligible for the other coverage, under certain circumstances. In order to qualify for this special enrollment period, the individual or dependent losing other coverage must request coverage under the new plan within 30 days of losing the prior coverage.[30] For example, consider a husband and wife who are eligible for enrollment under the husband's employer's group health plan, but decline enrollment because they are enrolled in the wife's employer's plan. If the wife terminates her employment, becoming ineligible for coverage under her employer's plan, the family must be permitted to enroll in the husband's employer's group health plan, as long as the family timely requests enrollment and satisfies certain other conditions. The couple does not qualify for this special enrollment period, unless coverage was terminated because the family became ineligible, because of an event such as death, divorce, termination of employment or employer contributions, or reduction of hours.[31] Loss of other coverage due to nonpayment of any required employee contribution does not give rise to a special enrollment right in a new plan.

A child who is covered pursuant to a QMCSO can lose coverage under the obligated parent's plan under circumstances that would not apply to other dependents. If the effective period for the order expires, the plan is no longer obliged to provide coverage. The special enrollment provisions described above do not address the issue of whether a child who loses coverage because a medical support order has expired would be entitled to special enrollment right in any other plan. Accordingly, the Working Group recommends that HHS and DOL request guidance from the appropriate Federal agencies as to whether a child who loses coverage because a QMCSO expires would be entitled to a special enrollment right in another plan. If an individual who is enrolled in a group health plan acquires a new dependent through marriage, birth, adoption, or placement for adoption, under certain circumstances the new dependent (and the spouse in the case of birth or adoption) are entitled to a special enrollment period.[32] During this period they must be permitted to enroll in the plan without regard to open season restrictions or waiting periods otherwise imposed by the plan. In order for this special enrollment right to apply, the plan must offer coverage to dependents, and a request for enrollment under the plan must be timely made. For example, consider a husband and wife who are eligible for enrollment in the group health plan maintained by the husband's employer, the wife voluntarily declines coverage. Later the wife gives birth to a child. The mother and child are entitled to a special enrollment period under the husband's employer's plan provided that the plan provides dependent coverage and a timely request for coverage is made.[33]

Circumstances Under Which Group Health Plans May Impose Preexisting Condition Exclusions

Plans cannot apply these exclusions to newborns or adopted children. HIPAA provides that if a child is enrolled in creditable coverage (certain types of coverage are considered HIPAA "creditable" coverage) within 30 days of birth, adoption or placement for adoption, group health plans may not impose preexisting condition exclusions against the newborn or adopted child.[34] In the case of adopted children, §609(c) of ERISA provides additional protections from these exclusions. Under 609(c), if a child is adopted or placed for adoption while a participant is eligible for coverage under a plan, the plan may not impose a preexisting condition exclusion against the child once the child is enrolled. The plan is prohibited from imposing such an exclusion regardless of the timing of the enrollment.[35]

The Working Group discussed the

Recommendation 60 (Federal Guidance/Federal Legislation)

DOL and HHS should request the IRS to provide interpretive guidance regarding whether the expiration of the period covered by the Qualified Medical Child Support Order is a COBRA qualifying event in ERISA §603(5) (a dependent child ceasing to be a dependent child under the generally applicable requirements of the plan). This interpretation would make it possible for the child support enforcement agency or custodial parent to elect COBRA continuation coverage to prevent a child from losing coverage for these reasons. If the current statute does not permit this interpretation, we recommend that Congress amend §603(5).

Recommendation 61 (Federal Regulation)

The DOL should issue regulation(s) that make it clear that ERISA §701(f)(1)(C)(ii) (special enrollment for individuals losing other coverage) permits a child to be specially enrolled in a new plan, after prior coverage obtained through a Qualified Medical Child Support Order (QMCSO) is terminated, if the coverage ends during the period covered by the order or at the end of the period covered by the order. This would permit a child to enroll in other available coverage provided by either parent, if coverage is terminated for some reason related to the medical support order.

Recommendation 62 (Federal Legislation)

Congress should amend ERISA §701(f)(2)(A)(iii) to include children enrolled pursuant to a QMCSO among the categories of dependents who, if certain other requirements are met, must be given special enrollment rights.

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possibility of extending similar protections from preexisting condition exclusions to children covered pursuant to QMCSOs as well as children who lose coverage because a QMCSO expires. Ultimately the Working Group was unable to reach consensus on these issues. Some members felt that prohibiting such exclusions could leave plans vulnerable to adverse selection, because parents could wait until children were sick before seeking or enforcing a QMCSO. The Group also struggled with the fact that HIPAA's protections apply only where enrollment of the child is within a specific time frame. The QMCSO process makes it difficult to identify a corresponding enrollment period for QMCSO children. The Working Group agreed that it was important to note that current law permits plans to apply preexisting condition exclusions of up to 12 or 18 months against children covered pursuant to QMCSOs. These exclusions make it difficult for these children to obtain seamless coverage through their parents' group health plans.

📄 See Recommendation 60, Recommendation 61, Recommendation 62.

Coordination of ERISA Medical Child Support Provisions with Social Security Act Medical Child Support Provisions

Section 1908 of the Social Security Act[36] requires states to have specific laws that would make it easier for children to obtain family health coverage under their noncustodial parent's health plans. These laws primarily impact children, noncustodial parents, and insurers, such as group health care plans and employers. While some provisions of §1908 pertain to parents who are obligated by a court or administrative order to provide medical support to their children, other provisions do not contemplate the existence of an order.

Some provisions of §1908 are unclear, so states have adopted various interpretations. For instance, §1908 does not clearly define the scope of its applicability. Since §1908 was placed in Title XIX of the Social Security Act, which governs the Medicaid program, it can be construed as requiring that State laws enacted pursuant to §1908 need only apply to children who are receiving or eligible for Medicaid benefits. While most states apply the laws required by §1908 to all children, some states limit the applicability of those laws to Medicaid children.

It is reasonable to conclude that Congress intended the State laws required by §1908 to apply to all children. The introductory language in §1908, by its own terms, casts §1908 as "medical child support" law. The statute does not specify Medicaid children, but refers to the laws as they apply to "a child." The specific language speaks of laws that impose limitations or prohibitions on insurers and employers. In addition to the plain language of the statute, considerations of insurance and health plan administration support this interpretation. If the State laws applied only to Medicaid children, insurers and employers would be faced with the burden of determining whether a particular child, who may live in another State, is eligible for or receiving Medicaid. See Recommendation 63.

Section 1908 requires states to enact laws that prohibit employers from terminating the coverage of a child who was enrolled in its group health plan pursuant to a court or administrative order unless, among other things, the employer eliminates family health coverage for all of its employees.[37] This could require the plan to maintain coverage of a child who was covered pursuant to a court order, although the employee's other children's coverage was terminated, because the parent did not pay required employee contributions. Similarly, if the employer terminates all group health plans for employees and dependents within a particular unit, such as a separate division or work site, §1908 seems to require the employer to continue to provide coverage to any child who was enrolled pursuant to an order, although the employee's other children and children of other similarly-situated employees would lose coverage. It is reasonable to conclude that Congress wanted plan administrators to treat children enrolled pursuant to orders in the same manner as other children of similarly situated parents, but did not intend to give those children greater rights to coverage than other similarly situated children.

Section 1908 also includes some provisions

Recommendation 63 (Federal Legislation)

Provided that Congress makes the following changes to §1908 of the Social Security Act (42 U.S.C. §1396g-1), Congress should also amend §1908 to state explicitly that the laws it requires States to pass as a condition of participation in the Medicaid program apply to all children (regardless of whether they are eligible for assistance under the State Medicaid plan), and should amend §609 of ERISA to incorporate the requirements of the amended §1908. The necessary changes are:

- Clarify that a child who is in enrolled in a group health plan pursuant to a court or administrative order could be disenrolled under circumstances under which other dependent children would lose coverage (for example, elimination of family health coverage for all employees in the same business unit or job category).
- Amend §1908(a)(1) to provide that, if there is no QMCSO, a child would be enrolled only if the participant enrolls or consents to the enrollment of the child.

that require states to impose requirements on insurers, even absent a court order. Section 1908 defines "insurer" to include a group health plan, as defined in §607(1) of ERISA. At the time §1908 was enacted, Congress also amended §514 of ERISA to lift ERISA preemption of State laws required by §1908 to the extent they apply to a QMCSO. Currently, State laws may be preempted with respect to a group health plan's obligation in the absence of a QMCSO.

Inconsistency between ERISA and §1908 may cause health plans to treat a child of a noncustodial parent who is not under a court order but wishes to enroll his child in his group health plan, differently from a parent whose child is enrolled pursuant to a court order. If two noncustodial parents work for the same employer, both with a child living in the same area, and one is ordered to provide health care coverage, while the other not, the noncustodial parent who is subject to an order might be able to enroll her child, while the other could not. ERISA should be amended to eliminate this disparate treatment.

Section 1908 does not define "family health coverage." An employer can offer a plan that covers the employee's dependents, without covering the employee. If such plans are not considered "family health coverage," children may not gain access to available coverage. 📕 See Recommendation 64.

Recommendation 64 (Federal Regulation)

The term "family health coverage" should be defined in regulations and guidelines to include health coverage that provides benefits to dependents, including a dependent only policy.

Endnotes

[1] Pub. L. 105-200, §401(a)(5)(iii), 112 Stat. 660 (1998).

[2] Child support agencies must determine whether children whose families are receiving services have health care coverage and have access to the financial information needed to determine whether the family qualifies for Medicaid or SCHIP.

[3] See, 42 U.S.C. §1396r-1a(b)((3) (1999). The Balanced Budget Act includes a provision that permits a "qualified entity" to determine a child's eligibility for Medicaid for a "presumptive eligibility period" based on preliminary information that the family income does not exceed the State's Medicaid income eligibility level. The presumptive eligibility period is the remainder of the month in which presumptive eligibility is determined plus the next month, about 29 to 62 days, and ends when the Medicaid agency determines "regular" eligibility. Qualified entities now include Medicaid providers, as well as agencies which determine eligibility for the Head Start, Child Care and Development Block Grant, and WIC programs. SCHIP does not similarly limit the entities that could determine presumptive eligibility.

[4] This model application can also be found at http://www.hcfa.gov/init/chpelig.htm

[5] The Balanced Budget Act of 1997 added a new optional Medicaid eligibility group that consists of children who by definition do not have health insurance. If the State uses this group to expand Medicaid, the children cannot have other insurance. However, if the State expands Medicaid by expanding another eligibility group in some way (such as putting a higher income level on a poverty-level-related group), then the State is required to cover the children whether or not they have insurance.

[6] Federal Register, Volume 64, No. 215, November 8, 1999.

[7] 42 U.S.C. §1397aa (1999).

[8] Federal Register, Volume 64, No. 215 on November 8, 1999.

[9] The cooperation requirement only applies to coverage for the mother. If she does not cooperate, the children may not be denied Medicaid coverage as a result.

[10] Virginia's SCHIP State Plan is located at: http://www.cns.state.va.us/dmas/images/PDF/statepln.pdf

[11] 42 U.S.C. §1397bb (1999).

[12] Mass. Ann. Laws ch. 118E, §9A (1999).

[13] Senate Bill 1248, 76th Legislature, effective September 1, 1999.

[14] Section 1902(a)(25) requires that a State plan for medical assistance provide "that in the case of an individual who is entitled to medical assistance under the State plan with respect to a service for which a third party is liable for payment, the person furnishing the service may not seek to collect from the individual (or any financially responsible relative or representative of that individual) payment of an amount for that service (i) if the total of the amount of the liabilities of third parties for that service is a least equal to the amount payable for that service under the plan (disregarding section 1916), or (ii) in an amount which exceeds the lesser of (I) the amount which may be collected under section 1916, or (II) the amount by which the amount payable for that service under the plan (disregarding section 1912) exceeds the total of the amount of the liabilities of third parties for that service."

[15] Section 1916 allows States to impose nominal cost-sharing amounts on Medicaid beneficiaries in specific situations. The statute does, however, prohibit the imposition of cost sharing for services for individuals under age 18 (with the State's option of raising the age limit to 21).

[16] Employee Retirement Income Security Act, which appears generally as 29 U.S.C. §1001 et seq. (1999).

[17] The Consolidated Omnibus Budget and Reconciliation Act of 1985, Pub. L. 99-272, codified in various sections of the U.S. Code.

[18] The Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936, codified in various sections of the U.S. Code.

[19] 29 U.S.C. §1167(3) et seq. (1999).

[20] 29 U.S.C. §1161.

[21] 29 U.S.C. §§1161-62.

[22] 29 U.S.C. §1167(3) (1999).

[23] 29 U.S.C. §1163 (1999).

[24] 29 U.S.C. §1181 (1999).

[25] 29 U.S.C. §1181(c) (1999).

[26] 29 U.S.C. §1181(d)(1) (1999).

[27] 29 U.S.C. §1181(d)(2) (1999).

[28] 29 U.S.C. §1181(f) (1999).

[29] 29 U.S.C. §1181(f) (1999).

[30] 29 U.S.C. §1181(f) (1999).

[31] 29 U.S.C. §1181(f)(1)(C) (1999).

[32] 29 U.S.C. §1181(f)(2) (1999).

[33] 29 U.S.C. §1181(f)(2)(A)(iii) (1999). "…in the case of the birth or adoption of the child, the

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spouse of the individual may be enrolled as a dependent of the individual, if the spouse is otherwise eligible for coverage."

[34] 29 U.S.C. §1[illegible]69(c) (1[illegible]99).

[35] 29 U.S.C. §11[illegible]1(d)(4[illegible](1999).

[36] 42 U.S.C. §13[illegible]6g-1([illegible](3)(C) (1999).

[37] 42 U.S.C. §13[illegible]6g-1([illegible](3)(C) (1999).

CHAPTER 7. The Question of Money: Paying for the Expanded Role of the IV-D Program in Obtaining Health Care Coverage for Children

Introduction

Historically, child support enforcement was a private matter, financed by parents and governed by State law. State and local governments became involved only if a child needed public assistance. For almost the past fifty years, however, there has been increasing Federal involvement in both the structure and the funding of child support activities.[1]

An examination of the historic funding of the child support enforcement program established in Part D of Title IV of the Social Security Act (IV-D) reveals that Congress has continually adapted program funding to encourage activities which it believes are important to program improvement.

☞ See box, "History of Federal Funding of the IV-D Program," page 7-2.

The IV-D program benefits from a generous Federal funding formula. In fiscal year 1997, the Federal government paid over $2.3 billion to States for the operation of child support enforcement programs. State and local governments appropriated an additional $1.1 billion.[2] The Federal contribution is essential to the success of the child support program. Federal funds defray a majority of the costs of State child support agencies, and are instrumental in determining the agencies' functions and directing the priorities of the program.

CHAPTER 7 AT A GLANCE

INTRODUCTION, 7-1
CURRENT IV-D FUNDING STRUCTURE, 7-3
POLICY ISSUES RELATED TO IV-D FUNDING, 7-4
  Enhanced Federal Financial Participation (FFP), 7-5
  Medical Support Performance Incentive Measure, 7-6
  Cross-Program Funding, 7-10

Theme

To improve the establishment, implementation, and enforcement of medical child support, the Working Group has made recommendations that will considerably enhance the responsibilities of child support enforcement agencies. IV-D agencies may need to undertake significant restructuring in order to incorporate new options, and new tools, into their core functions. Without sufficient resources, the Working Group's recommendations cannot be implemented and many of the identified barriers to medical child support enforcement will remain. This chapter lays out a Federal funding scheme to support, and ultimately reward, successful implementation of these recommendations by IV-D agencies.

History of Federal Funding of the IV-D Program

In 1950, without providing funding, Congress required welfare agencies to inform appropriate law enforcement officials when AFDC was furnished to a child who had been abandoned by a parent. The rationale was to encourage law enforcement officials to take action, including the filing of non-support proceedings against those who had abandoned their children.[3]

In 1967, recognizing that its earlier efforts had met with limited success and that many families became dependent on welfare because they could not obtain child support, Congress required states to set up a single State organizational unit to take responsibility for establishing paternity and obtaining child support for deserted children who receive AFDC. Federal funding at a 50% Federal Financial Participation (FFP) matching rate was made available for this important purpose.[4]

In 1975, recognizing that better child support enforcement might reduce the need for families to resort to welfare, Congress added Title IV, Part D, to the Social Security Act. Rather than expanding upon the requirements already contained in Title IVA, Congress chose to create a separate program. This change emphasized a major break with the past: the new program was to serve non-AFDC families as well as those receiving AFDC. Moreover, the Federal government substantially increased its funding for child support activities. FFP at a 75% rate was made available for serving *both* AFDC and non-AFDC cases.[5] This legislation also provided states with "incentive payments" when they made cash collections in AFDC cases: the State could retain 25% of the amount collected for a family for the first 12 months of collection and 10% of the amount collected thereafter.[6]

In 1980, the FFP rate was altered in several significant respects. To encourage the states to automate their child support systems, the FFP matching rate for automation activities was raised from 75% to 90%. At the same time, in order to have the states pick up a greater share of basic program costs, FFP was reduced from 75% to 70% effective October 1, 1982. The incentive payment formula was also changed. States were given a flat 15% of all AFDC collections as an incentive.[7]

In 1984, the funding changed again. FFP for basic program functions was reduced, over a three year period, from 70% to 66% where it remains today. To encourage automation efforts, however, FFP at the 90% level remained available and hardware costs were made reimbursable at this higher rate. A new incentive payment structure was also put in place. This structure rewarded states for making collections in non-AFDC as well as AFDC cases.[8]

In 1988, to emphasize the growing importance of establishing paternity, Congress provided 90 percent FFP for the laboratory costs associated with determining paternity.[9]

In 1998, Congress again changed the incentive payment system. Incentive funding was now to be based on the performance of States in key areas. This was a significant step away from a compliance-based system to performance. Incentive payments are now provided for establishing paternity, establishing support orders, collecting current support, collecting arrears and cost-effectiveness.[10] Congress also asked that an incentive payment formula for medical support enforcement be developed. At the same time, Congress capped the amount of money available for incentive payments.[11]

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With this context in mind, the Working Group analyzed the funding stream for activities related to medical child support enforcement and the impact the funding mechanisms have on policy choices. The recommendations that follow support the programmatic reforms addressed elsewhere in this Report or that may arise with further study.

Current IV-D Funding Structure

Funding for the child support enforcement program is provided in three general ways.

❶ Federal Administrative Funding

The largest share of program funding comes from Federal administrative funds. The Federal government provides 66 percent of the operating funds for State child support programs.[12] Federal funding at this rate is "open ended" in that it pays its percentage of expenditures by matching the amount spent by State and local governments, with no upper limit or ceiling. Federal law and regulations dictate the specific expenditures for which this 66 percent FFP is available, and the Federal government reviews expenditures to determine whether they were reasonable.[13]

FFP
Federal Financial Participation

❷ State and Local Administrative Funding

In order to receive any Federal funding, State and/or local governments must provide 34 percent of the funds needed to operate their child support enforcement programs. Most States pay for a majority of child support expenditures from the State's general revenue. Some states pay administrative costs from the portion of TANF child support collections retained by the State. In some States, county governments pay a portion of or the entire State share. States also have the option to charge fees and recover costs for services from the custodial and/or noncustodial parent.[14]

❸ Incentive Payments

Federal incentive payments are designed to encourage States to operate efficient, cost-effective child support programs

A new incentive-funding scheme for child support enforcement will be phased in, beginning in fiscal year 2000.[15] New performance measures, developed by OCSE, in consultation with State IV-D Directors, in response to law enacted by Congress in 1996, developed base incentives on the program's success in achieving a number of goals, in addition to its ability to provide services in a cost-effective manner.[16] Incentive payments are tied to the rates of paternity establishment, order establishment, collection of current child support payments, and collection of arrears, as well as the amount of support collected for each dollar spent.[17]

The Federal government provided incentive payments totaling over $411 million to State child support enforcement programs in fiscal 1997. Incentive payments will be capped at $422 million in fiscal year 2000, and gradually increase to $483 million in fiscal year 2008.[18] States must reinvest the full amount of Federal incentive payments in their child support programs.[19] Incentive payments, whose performance measures mirror program goals, should encourage states to improve their child support programs and comply with Congressional goals.

Policy Issues Related to IV-D Funding

As noted above, the Federal government provides 66 percent of the funding for most IV-D program activities, including those related to medical support. In the past, when Congress wanted to encourage activity in a given area, it offered FFP at a higher level. For example, Congress provided enhanced FFP to encourage paternity establishment and automation. The Working Group believes that Congress should provide enhanced FFP at the 90 percent rate for medical child support activities to encourage states to more aggressively pursue medical support enforcement.

At the current time, States are faced with new initiatives and competing priorities to medical child support enforcement activities at the State level. While recognizing the importance of medical support, IV-D agencies are fully occupied. Agencies report being occupied with implementing new mandates and the critical role child support collections play in welfare reform. In a world of limited TANF benefits, full and timely collection of child support is a lynchpin, critical to the economic self-sufficiency of millions of single parent families.

CSPIA
Child Support Performance and Incentive Act of 1998

Both CSPIA and the Working Group's recommendations require State child support agencies to assume new responsibilities. The Working Group's recommendations and existing Federal legislation require major systems changes for IV-D agencies, which are still struggling with PRWORA's automation requirements. Some examples of the additional demands for automation and for casework services that medical child support enforcement—under current law and as proposed in this Report—places on IV-D agencies include:

- Implementation of the NMSN
- Implementation of PRWORA's requirement that every child support order include provision for health care coverage

NMSN
National Medical Support Notice

- Implementation of new automated systems capable of exchanging information with employers and family health coverage plans
- Implementation of additional Working Group recommendations, including recommendations that child support agencies make a presumptive determination of eligibility for Medicaid and help children obtain public health care coverage when they do not have access to private insurance
- Implementation of the requirement that child support agencies consider health care coverage available to the custodial parent

The Working Group concluded that child support enforcement agencies cannot be expected to fulfill these critical mandates unless they are able to hire and train adequate staff and fund the enhancement of systems. Congressional authorization of additional funding for medical support is essential to improved IV-D performance in this area.

The funds that State and Federal governments devote to medical child support will be key to improving medical support enforcement, and implementing reforms. Enhanced FFP and a new incentive measure for the IV-D program will provide important sources of funding to help State child support agencies ensure that every child who is eligible for child support services has comprehensive health care coverage.

Enhanced Federal Financial Participation (FFP)

Congress has successfully used enhanced funding to "jump start" State implementation of new child support activities. For example, in the Family Support Act of 1988 Congress provided 90 percent enhanced FFP to defray laboratory costs incurred in establishing paternity.[20] This enhanced FFP contributed to dramatic increases in the number of IV-D cases where paternity was established.[21]

Enhanced Federal funding for establishing and improving State automated child support systems similarly made it possible for States to comply with requirements in the Family Support Act and PRWORA that they create highly automated child support enforcement systems.[22] These systems are designed to make it faster and easier to establish and enforce child support orders and to distribute the payments received. When completed by all jurisdictions, they are expected to make the child support program more efficient and cost-effective.

As with these priority areas, enhanced FFP would highlight the importance of medical support and give the states the resources they need to implement CSPIA'S medical support requirements and the Working Group's recommendations. However, the Working Group recognizes that the Federal government cannot be asked to provide an open-ended commitment to funding medical support activities. States will need to assume greater responsibility for funding medical support. Thus, the Working Group recommends that Congress offer an enhanced 90 percent FFP rate for medical support activities ***but only for a limited 5-year period.***

By offering this "carrot" and prioritizing IV-D medical support activities, Congress would use the power of the purse to ensure prompt and effective implementation of Title IV-D's medical support provisions and the Working Group's recommendations. This funding could be capped in order to limit the total amount of Federal funding earmarked for enhanced medical support and to help Congress predict the cost of implementing these provisions. See Recommendation 65.

Medical Support Performance Incentive Measure

In 1998, Congress established a new incentive payment scheme, mandated by CSPIA, which rewards performance in five areas.[23] At the same time, it capped the total amount of Federal incentive payments that would be made available to the States. The new system is currently being phased in, and will be fully implemented in FY 2002.[24]

CSPIA also authorized creation of a sixth incentive measure, medical support enforcement.[25] This legislation required that the medical support performance measure be incorporated, ***in a revenue neutral manner***, into the performance measures already established by Pub. L. 105-200. Once a medical support performance measure is adopted, medical support will be added to the list of activities for which states can receive incentive payments. However, States will still be competing for the same pot of money, which will be divided based on six factors rather than five.

CSPIA authorized the Secretary of HHS to develop a medical support incentive measure in consultation with State IV-D agency directors and representatives of children eligible to receive child support. The Medical Support Incentive Work Group began meeting in 1998. The statute requires that the incentive measure be based on the

Recommendation 65 (Federal Legislation)

Congress should amend Federal law to provide for 90 percent enhanced Federal Financial Participation to State IV-D agencies for a five-year period to facilitate the implementation of the Title IV-D medical support requirements, contained in §401 of CSPIA 1998, and additional Federal requirements that result from the Working Group's recommendations. This funding may be capped.

States' effectiveness in establishing and enforcing medical child support obligations. The Medical Incentive Support Work Group's final report to Congress is due on June 1, 2001.[26]

Developing a medical support performance measure has proven a difficult task. The Medical Support Incentive Work Group's June 23, 1999 preliminary report to Congress states that the primary obstacle is the lack of reliable data upon which a measure can be based.[27] At last review by OCSE's audit division, only seven states could provide medical support data—and that data was considered to have limited reliability. This problem will be addressed through the new State IV-D reporting requirements,[28] but it will be at least a year before this process provides enough reliable and accurate data to design a truly useful performance indicator.

The Medical Support Incentive Work Group also expressed concern about the benefits of implementing a performance measure before states actually have adequate tools to improve their performance in this area. The NMSN, which will be key to improving medical support enforcement, will not actually be finalized and in broad use until FY 2002. For all of these reasons, the Medical Support Incentive Work Group recommended postponing implementation of the performance measure.

> *..... it's absolutely critical that at some point down the line, when the dust is settled on what the IV-D program's responsibilities are in terms of medical support, that we have an appropriate performance measure and we evaluate our progress.*
>
> **~Lee Sapienza, Chief of Policy and Planning, Office of Child Support Enforcement, New York**

In the interim, the Medical Support Incentive Work Group will be reviewing State-reported data regarding the number of cases in which: (1) medical support (cash and/or family health coverage) is ordered; (2) health care coverage is ordered; or (3) health care coverage is provided as ordered. In addition, the Medical Support Incentive Work Group contemplates a system which rewards continuous improvement, as well as current performance. Given the historic inattention to medical support issues, it is important to measure improvement, so that States with poor records can hope to earn incentives by significant annual improvement.

The Working Group concurs with the Medical Support Incentive Work Group's judgment that a performance measure should be developed but that data is not yet available to do so. The Working Group also agrees that the Medical Support Incentive Work Group should develop measures that reward the full range of medical support activities, including securing and enforcing health care coverage in IV-D cases, contributions toward premiums, and other health care reimbursement. Consistent with the Decision Matrix adopted by the Working Group, the Medical Support Incentive Work Group should devise a measure that rewards States for enrolling children in the most *appropriate* coverage, whether that is private or public. The incentive payment scheme should reward States which screen cases and follow through, so that children who cannot obtain private coverage are enrolled in public coverage, such as Medicaid or SCHIP.

The Working Group supports the idea of a standard that sets minimum acceptable performance levels and rewards significant improvement over that level. Finally, the Working Group also agrees with the Medical Support Incentive Work Group's finding that the states need to have access to the tools needed to improve their performance, before Congress establishes a performance measure.

A number of the recommendations made in this Report require changes in Federal law and regulations, which will occur over a period of time. Furthermore, the results of demonstration projects suggested in Chapter 8 are designed to provide additional insight into ways to further improve medical support enforcement. These results are several years away. For these reasons, the Working Group recommends that the medical support incentive payment system be developed and implemented in conjunction with other funding recommendations. 📄 See Recommendation 66.

Members debated whether a proposed five-year delay in implementing the performance measure for medical support was a *de facto* approval of putting off improvements in medical support enforcement. The Working Group also struggled with counterbalancing concerns that the automated reporting system does not adequately reflect medical support activity while counting such activities without automation would distract from the provision of direct service to the children.

📄 **Recommendation 66 (Federal Legislation)**

Congress should amend Federal law to require that the medical support incentive measure is developed in conjunction with the implementation of CSPIA 1998 §401 requirements and additional requirements that may be imposed by law or regulation, based on the recommendations of the Working Group. The measure should also take into account the findings of the research and demonstration grants undertaken by States and funded by HHS.

With the need for the development of outcome measurements—not only for the existing requirements but also for any that are implemented due to the Working Group's recommendations—delay was unavoidable. But the consensus was that a full 5-year delay for development and implementation of this incentive measure was untenable. The consensus reached balances the practical considerations described above with the need to send the message that medical support activities must happen sooner—not later.

The Working Group does not favor indefinite postponement of State accountability for improved medical support enforcement. Indeed, some members of the Working Group felt that postponement of the medical support performance incentive measure might give states an undeserved reprieve, since medical support requirements are not new to the IV-D agencies.[29] A number of Working Group members found the lack of data disturbing in light of existing statutory requirements. They feared that postponing implementation of a medical support incentive system would reward states that have long ignored medical support.

Others observed that postponing implementation of the medical support incentive measure could send the wrong signal to State child support agencies. The Working Group's decision to develop and implement this incentive measure in conjunction with other efforts should not be interpreted as a decision to downgrade the importance of medical support in the child support enforcement program. The Working Group wants to stress that the period of enhanced FFP should be used as a time of preparation for and focus on making medical support a core child support activity. Otherwise, children could needlessly be denied health care coverage, at great cost to private insurers, public health care programs, and most importantly the children themselves.

Ultimately, the Working Group concluded that enhanced FFP *for a limited time period* would focus states' attention on medical support, and generate increased State activity in the medical support area. This funding would expire after five years. Thus, it seemed appropriate to propose a plan in which the medical support incentive payment would be phased in and become fully operational as enhanced Federal funding ends. To achieve this, the medical support incentive measure must be developed as quickly as possible.

The Working Group recommends that the Medical Support Incentive Work Group continue its work and develop its recommendations, so that the medical support performance indicator will be published in final form within three years of the date enhanced FFP becomes available. At that point, OCSE should begin gathering the data needed to assess State performance, so that the medical support performance indicator will be fully implemented into the incentive payment system when the enhanced Federal funding expires at the end of the five-year period.

Under this approach, CSPIA's requirements will be fully implemented, and recommendations of the Working Group should be in place before the incentive payment becomes fully operational. In the meantime, enhanced FFP will make it possible for states to fund more concerted efforts in the medical support area. When enhanced funding ends, the incentive payments system will reward states for continued, focused, medical support activity, and they will have the tools necessary to ensure that medical support is consistently ordered and enforced. See Recommendation 67.

Cross-Program Funding

Most Working Group members agree that medical support efforts of the IV-D agencies have resulted in savings to the Medicaid program. Identifying the savings to the Medicaid program (and the cost avoidance to SCHIPs) when the IV-D agency obtains coverage on behalf of Medicaid and SCHIP recipients is an important and complex matter that the Working Group strongly believe merits further study.

So that IV-D agencies benefit from their efforts to obtain third-party private health insurance, State Medicaid agencies could share these cost savings with the IV-D agencies. New York State, for example, estimates that for every Medicaid child who has private health care coverage available, there is a potential Medicaid savings of $666 per year.[30]

Since receipt of such savings could be a strong incentive to the IV-D agency to enroll children in private health insurance, the

Recommendation 67 (Federal Legislation)

Congress should amend Federal law to require HHS to publish the medical support performance incentive measure in final form within three years of the date the 90 percent FFP goes into effect. Implementation of the medical support performance incentive measure shall begin upon publication including the collection and submission by the States to OCSE of all data necessary to calculate the measure. The medical support performance incentive measure shall be included in the calculation of incentive payments due States beginning 2 years after publication. This five-year time period shall run concurrent with that set forth in Recommendation 65 (Federal Legislation).

medical support incentive measure could be used to better identify these savings, with the IV-D, Medicaid, and SCHIP agencies collaborating in establishing the appropriate reporting requirements.

The Working Group identified several complications in the measurement and distribution of such savings. First, much of the Medicaid savings realized through medical child support collection will be through cost avoidance instead of cost recovery. Expenses that are cost avoided do not show up in accounts receivable as a specific amount. Not only is it very difficult to determine accurately the exact amount of Medicaid spending that has been cost avoided, but there is no "pot of money" in which cost-avoided funds reside.

Second, because IV-D agencies receive a higher rate of FFP than Medicaid agencies, a policy of direct cross funding from the Medicaid agency to the IV-D agency could result in an overall loss of State funds (as more of the savings would need to be returned to the Federal government).

> *"[W]e should explore the possibility of cross-program funding and ... we should use that possibility as a vehicle for rewarding effective performance. It's very consistent with the whole of CSPIA,[so that] when IV-D agencies actually do good jobs in medical support enforcement, they benefit from cost-avoiding in the Medicaid program."*
> **~Ruth Bell Clark, National Child Support Association**

Because of its potential and its complexity, the Working Group urges further study of this possibly useful practice. See Recommendation 68.

The implementation of CSPIA IV-D medical support requirements and the changing tide of health care coverage available to families both from private and public sources gives rise to a need for evaluation of the effectiveness of child support's involvement in medical support enforcement and the interface between programs. To that end, Chapter 8 sets forth areas where research and demonstration projects are required. Of particular relevance

Recommendation 68 (Research and Demonstration)

HHS should study the savings and cost avoidance to the Medicaid program when IV-D secures and enforces a medical child support order for private insurance for Medicaid-eligible children. HHS should also study alternate methodologies to supplement funding for the child support enforcement program based on such Medicaid program savings and avoided costs. If HHS does not have sufficient funds to meet the cost of such a study, it should seek an additional appropriation from Congress.

to cross-program funding is Recommendation 70. The Working Group urges Congress and the Executive branch to support such research and demonstration through appropriate funding.

Endnotes

[1] See Krueger, Ruth Gillie. "Analyzing American Social Policy: A Study of the Development of the Child Support Provisions of the Personal Responsibility and Work Opportunity Act of 1996 (PRWORA)." Dissertation presented to the University of Southern California School of Public Administration (December 1998); Committee on Ways and Means, U.S. House of Representatives, "The Child Support Enforcement Program: Policy and Practice." U.S. Government Printing Office (December 5, 1989).

[2] U.S. Department of Health and Human Services, Administration of Children and Families, Office of Child Support Enforcement, Twenty-second Annual Report to Congress, Table 1. *Financial for Five Consecutive Fiscal Years.*

[3] Section 402a of the Social Security Act, 42 U.S.C. §402(a)(ii).

[4] Pub. L. 90-248.

[5] However, for the first five years of the program, FFP for non-AFDC cases was somewhat problematic. In 1980, financing for non-AFDC cases was made permanent.

[6] Pub. L. 93-647, 42 U.S.C. §651 et seq.

[7] This figure was reduced to 12 percent effective October 1, 1983. Pub. L. 96-178, Pub. L. 96-265, Pub. L. 96-272.

[8] Pub. L. 98-378.

[9] Pub. L. 100-465.

[10] 42 USC §658a. This new system is being phased in and will be fully operative in FY 2002.

[11] Pub. L. 105-200, § 401 112 Stat 659 (1998).

[12] 42 U.S.C. §655(a) (1999); 45 C.F.R. 304.20 (1999).

[13] 42 U.S.C. §655(a) (1999); 45 C.F.R. 304.20 (1999).

[14] Fees received and costs recovered for non-TANF cases totaled $40,797,848, in fiscal year 1997, (Twenty-second Annual Report to Congress, Table 22).

[15] 42 U.S.C. §658a (1999).

[16] 42 U.S.C. §658A (1999). This approach was endorsed by the U.S. Commission on Interstate Child Support Enforcement in its Report to Congress, "Supporting Our Children, a Blueprint for Reform" (1992), 288.

[17] 42 U.S.C. §658a(b)(4). The incentive measures are as follows:
a) Paternity Establishment: The ratio of children in the State or IV-D caseload who were born out of wedlock and have paternity established compared to the total number of children in the State or IV-D caseload who were born out of wedlock in the prior year.
b) Order Establishment: The percentage of IV-D cases with support orders.
c) Collection Rate: The IV-D collection rate for current support due.
d) Collection of Arrearage: The percent of IV-D arrearage cases paying.
e) Expenditures:Collections Ratio: The total dollars collected per dollar of expenditures.

[18] 42 U.S.C. §658a (1999).

[19] 42 U.S.C. §658a(f)(1999).

[20] 42 U.S.C. §655(a)(1)(C) (1999).

[21] Office of Child Support Enforcement, Twenty-second Annual Report to Congress and Twenty-first Annual Report to Congress.

[22] 42 U.S.C. §654(16), 42 U.S.C. §655(a)(1)(1999).

[23] 42 U.S.C. §658a (1999).

[24] *Id.*

[25] Pub. L. 105-200 §201(d)(6)(E), 112 Stat. 657 (1998), codified at 42 U.S.C. §658a, note 2 (1999).

[26] *Id.*

[27] HHS, Report to Congress on the Development of a Medical Support Incentive for the Child Support Enforcement Program (June 23, 1999), 1.

[28] HHS, Report to Congress on the Development of a Medical Support Incentive for the Child Support Enforcement Program (1999), 2.

[29] Since the 1980s child support agencies have been required to enforce medical support. See Pub. L. 98-378, the Child Support Amendments of 1984.

[30] New York State Department of Health, Office of Medicaid Management.

CHAPTER 8. Shaping the Future: Strategies for Ensuring Ongoing Improvements

Introduction

The Working Group learned many important lessons through its deliberations. Two of the most important were: (1) we do not have all the solutions to improving health care coverage for children, and (2) the IV-D program *by itself* cannot "fix" the health care coverage problem for children, even for those children receiving services through the IV-D system.

One of the major tasks of this first decade of the twenty-first century will be to build consensus on what we as a society want from our system of health care delivery. To do this the private and public sector must form a partnership that will weigh and balance the health care concerns of all segments of society. Just a few of the issues that need to be considered are: the relative importance of health prevention and medical treatment; the health care needs of the aging baby-boomers relative to those of young adults and their children; the role of employers and the private insurance industry as the primary provider of health care coverage and the role of government in filling gaps in that coverage; the impact of

CHAPTER 8 AT A GLANCE

INTRODUCTION, 8-1
FINDING NEW SOLUTIONS, 8-2
  Using the New Hire Process to Collect Health Care Coverage Information, 8-2
  Learn More About What Works, 8-4
  Developing "Fill the Gap" Coverage, 8-7
BETTER COORDINATION OF POLICIES AND PROGRAMS, 8-9
  Building Better Partnership for Health Policy Oversight, 8-11
    National Policy Coordination Group, 8-11
    Federal Regulatory Coordination Group, 8-12
  Containing Health Care Cost, 8-13
  Consumer Education and Preventive Health Care, 8-13
REVIEW OF TAX POLICY, 8-14

Theme

To give children the opportunity for health care coverage will require the development of new strategies that keep up with the changes in the labor force, health care, family structure, and public programs. Research and demonstration activities can help improve coordination of coverage, fill gaps, and identify new and better ways to get coverage to children. Collaborations within and among Federal and State agencies can help contain costs, identify problems, and make mid-course corrections. Like the old paradigm for Medical Support, the new ideas presented in this Report will become obsolete; knowledge development and coordinated efforts will keep our joint efforts relevant to changing conditions.

utilization and technological advancements on health care costs; and the appropriate balance between "market" forces and government intervention. All of the choices that we as a society make about our health care system will have consequences for our ability to ensure health care coverage for children.

The development of strategies to improve health care coverage for children must be the on-going responsibility of all the stakeholders—parents, employers, private and public health care plans and providers, courts, State and Federal agencies—and of society as a whole. This chapter considers how we can continue to make long-term improvements in health care coverage for all children.

Finding New Solutions

The Working Group identified a number of important areas where improvements needed to be made but where information was insufficient to ensure that national adoption of a particular policy would have a uniformly positive affect. To further explore or evaluate these ideas through research and demonstration activities seemed to be a reasonable approach. Once tested, the findings of these activities might result in national program or policy modifications or technical assistance and best practice dissemination. An important aspect of the research and demonstration activities is to assess the impact of change on all the relevant stakeholders, and not to focus exclusively on the IV-D perspective.

> *"...we've got to look forward and not see just what exists today and how health care is delivered today, but also what might be on the horizon for the future, and what changes could we expect for future generations?"*
>
> **~Cornelia Gamlem, Vice President at Large, Society for Human Resources Management**

Using the New Hire Process to Collect Health Care Coverage Information

The need for information about health care coverage whenever the obligated parent started a new job was recognized as critical if the IV-D agency was to keep health care coverage current. The Working Group discussed strategies that might allow for automated or routine collection of this information rather than seeking it on a case-by-case basis. This would maximize the efficient use of the Notice. One option discussed was to include health care coverage information as part of the New Hire Reporting process.

The New Hire Reporting system requires employers to provide the State with the name, address, and social security number of each new employee within 20 days of hiring.

This information is then matched with the State's child support enforcement data base to identify noncustodial parents who are being sought for paternity or award establishment or for enforcement of a child support order. If there is a match and a noncustodial parent owes support under an existing order, the State issues a Notice to Withhold Income for Child Support that instructs the employer to withhold child support from the employees wages.[1] This process, especially when fully automated, can significantly reduce the amount of time needed to put a wage-withholding order in place. Adding health care information to this process would make the collection of information routine and give the IV-D agency a head start on putting new coverage in place.

Eleven States currently ask employers to provide health care coverage information as part of their New Hire process. The Working Group members contacted the States and ascertained that reporting is mandatory in Iowa and Rhode Island and voluntary in the other nine States—the District of Columbia, Georgia, Kentucky, Maine, Maryland, Montana, New Mexico, Oklahoma, and Tennessee. Preliminary information from those States was considered inconclusive. States with voluntary reporting provisions indicated that the number of employers who reported the information was limited. No State had conducted an analysis of whether the information collected at the time of hire was still accurate at the time the employee became eligible to enroll for health benefits.

In addition, representatives of the employer community were concerned that increased reporting requirements for employers may have unintended consequences. The Federally mandated elements of the New Hire system are synonymous with other Federal reporting requirements, making compliance by employers very quick and easy. To the extent that employers have to spend more resources to comply with new Federal requirements, they have less money to spend on benefits for employees. This is especially true of small employers.

The Working Group recognizes that a quick, routine, and universal reporting system for health care coverage data could facilitate a more automated approach to issuing the Notice and, therefore, increase the number of months that child support-eligible children are enrolled in private health care coverage. However, in the absence of firm evidence that the benefits of using the New Hire Reporting system to obtain this data would outweigh costs, the Working Group recommends that HHS quickly undertake a study of states where employers currently report such information. This study should examine both mandatory and voluntary reporting. See Recommendation 69.

Learn More About What Works

SCHIP
State Children's Health Insurance Program

The Working Group understands that its recommendations have profound implications for the IV-D, Medicaid, and SCHIP programs. Envisioning a more seamless interface between these agencies and between private and public coverage than currently exists, the next several recommendations highlight the need for research, demonstrations, and studies that will help the public and private sector build a more effective and efficient system of coverage.

Better coordination and communication is needed if children are to be enrolled in the most appropriate private or public coverage each time a support order is entered. Such coordination is even more important to ensure continuity of coverage as children move between public and private coverage or to a different private provider.

Information is also needed in order to document funding needs for IV-D medical support services and to determine the amount of public medical cost savings attributable to child support agencies' efficient handling of medical support. Such issues take on further importance and become more complex in interstate cases.

Current Federal law requires the Secretary of HHS to issue regulations that will facilitate the exchange of information on available family health coverage between IV-D and Medicaid agencies.[2] Furthermore, current Federal policy requires SCHIP plans to include procedures to ensure coordination with other public and private programs that provide health coverage for low-income children.[3] Factors such as high case loads and manual procedures, as well as other systemic factors, may impede required coverage coordination and data exchanges between these programs. There is presently no set of known best practices that, if adopted, would facilitate coordination and

Recommendation 69 (Research and Demonstration)

The Federal OCSE should conduct a study of the 11 States that ask employers to submit health care coverage information as part of their New Hire Reporting process. The study should analyze the costs and benefits of these efforts from the point of view of employers and States, consider the privacy issues raised by such an information exchange, and identify any precautions taken to protect the privacy of case participants. The results shall be communicated to the States and to the Congress.

If HHS does not have sufficient resources available to fund these studies and/or demonstration projects, the agency should seek an additional appropriation from Congress.

communication between these programs. Consequently, children who are eligible often go without public health care coverage, while others receive coverage from Federally-funded sources, although appropriate private coverage is available. Documenting and sharing best practices would increase the potential for getting children into the right coverage option.

Most children enrolled in Medicaid are allowed to maintain both Medicaid and private coverage concurrently. Whenever this occurs, the private coverage is intended to be the primary source of coverage, leaving Medicaid to pick up where the private coverage leaves off. HCFA refers to this as "wraparound" coverage. This also provides continuous coverage for children who lose Medicaid coverage.

Conversely, with respect to SCHIP, children are not allowed to be enrolled in a separate SCHIP plan and private coverage concurrently. This makes it an ineffective source of "back up" coverage for low-income children who do not qualify for Medicaid. Parents who have access to family health care coverage at little or no cost may choose not to enroll their children in the plan because SCHIP provides needed services that are not covered under the parent's private group health plan.

Permitting children who are covered by other health care plans to enroll in SCHIP would eliminate the problem of crowd-out, and provide children with continuous coverage if they become ineligible for SCHIP or lose coverage under their parent's health plan. This also would ensure a smooth transition from Medicaid plus private coverage, to SCHIP plus private coverage, to only private coverage as the parents' incomes rise. The Working Group recommends that HCFA use its authority to authorize demonstrations allowing States to permit SCHIP enrollees to have other coverage.

The movement towards managed care plans also complicates dual coverage coordination. While some managed care plans have interlocking agreements to pay for or provide treatment for each others enrollees, it was reported by Working Group members that some managed care plans do not seek reimbursement from another managed care plan (and for routine care, may not seek reimbursement even from a fee-for-service plan). In the context of child support-eligible-children enrolled in Medicaid managed care plans, this may mean that the noncustodial parent is paying premiums for health care coverage that is never used by her children.

Some states have developed policies and procedures to avoid unreimbursed or underutilized coverage. For example, Massachusetts has developed procedures where children with private fee-for-service coverage are not enrolled in the Medicaid managed care plan, but are placed in its alternative fee-for-service Medicaid program. This allows the Medicaid program to only pay for Medicaid services not covered by the private plan. Alabama has developed system edits to ensure that managed care providers do seek appropriate third-party reimbursement when private coverage for children is obtained. The Working Group believes that such practices should be encouraged and that additional innovative ways of coordinating coverage should be developed so that the utilization of managed care does not have the unintended consequence of increasing Medicaid costs or reducing children's enrollment in private health care coverage. See Recommendation 70.

Recommendation 70 (Research and Demonstration)

HHS should undertake projects that will examine various aspects of the intersections of child and medical support enforcement. These projects will encourage States to implement the Working Group's recommendations and promote further innovations to expand health care coverage for children. The projects may be, but should not be limited to, §1115 demonstrations and Child Support Enforcement State program improvement grants projects. These grants might examine issues such as:

- States' efforts to coordinate health care coverage availability between the Child Support, Medicaid, TANF, and SCHIPs programs
- Best practices in establishing and enforcing private family health coverage
- How automation/technologies can be used to improve medical child support enforcement and save tax dollars
- States' creative use of cross-program funding to promote medical support enforcement including, but not limited to, SCHIP block grant funds, PRWORA-related Medicaid matching funds, Federal TANF or States' maintenance of effort funds (MOE), and other block grant funds
- The availability of private family health coverage to IV-D families with an emphasis on access, cost, and comprehensiveness of family health coverage
- State-specific demographic and economic variables that impact performance and States' ability to improve medical support enforcement performance

If HHS does not have sufficient resources available to fund these studies and/or demonstration projects, the agency should seek an additional appropriation from Congress.

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Developing "Fill the Gap" Coverage

One barrier to achieving health care coverage for all child support-eligible children is that not all parents (even when both parents' health care coverage is considered) have access to affordable employer-based dependent health coverage.[4] While many children may be eligible for Medicaid or SCHIP, some are not. About one half million children who live in child support-eligible families with incomes over

Sacramento IV-D Kids Medical Insurance Project

In 1995, when California's child support enforcement responsibility was still vested in each of its 58 counties individually, Sacramento County instituted a unique public-private partnership approach to providing affordable health care coverage for children by contracting with several providers for a child-only pool of reasonably priced "group rate" insurance that met medical support requirements. All children in the IV-D system are eligible for this coverage.

The IV-D Kids Program targets a significant health coverage gap—children whose parents do not meet income eligibility criteria for Medicaid or SCHIP and yet cannot afford the cost of private coverage. Like the SCHIP program, IV-D Kids insurance is offered by private-sector insurance companies. Unlike SCHIP, IV-D Kids insurance is available regardless of income level, and the premiums are directly paid by parents, rather than from public funds. Non-resident parents whose income exceeds SCHIP guidelines pay the full unsubsidized cost of this health coverage.

Some of the unique features responsible for the success of this program include the fact that there is no separate application process for the parents. Instead, the court adds the modest cost of the premium to the basic child support order at the hearing when ordering health coverage for an otherwise uninsured child. Employers of non-resident parents are directed, via a wage assignment, to forward insurance premium payments from the employees' wages to a third party administrator. Self-employed non-resident parents send premiums directly to the administrator. The administrator signs up the child with the provider, pays the premiums and alerts the custodial parent and the IV-D Agency when the payment is not received. In order to prevent the policy from lapsing for nonpayment, the custodial parent could meet the obligation while the child support agency is investigating the delinquency. In the future, California plans to implement an "insurance buffer zone" that will allow IV-D Kids insurance benefits to continue if the non-resident parent is briefly unemployed or experiences a short-term drop in income (to below guideline amounts).

Experience has shown that by increasing the number of children in the insurance pool, the IV-D Kids program could expand benefits (in particular, to include dental and vision benefits). It is anticipated that California's newly centralized Department of Child Support Services will achieve this goal by expanding the scope of this program to create an avenue though which all 29 of the State's CHIP providers will be accessible through the IV-D Kids program.

Additional modification to ensure coverage regardless of parents' income level will be developed as California gains more experience with this program.

200 percent of poverty have no private or public health care coverage during a year.[5] In addition, many other children do not have continuous coverage, and these children also need better health care coverage. The IV-D agencies are ideally situated to identify, rapidly and easily, these children who lack medical insurance coverage.

See box, "Sacramento IV-D Kids Medical Insurance Project," page 8-7.

Certain public-private arrangements, such as the Sacramento IV-D Kids program have had modest success in providing affordable coverage for children not otherwise eligible for Medicaid or SCHIP. The Working Group recommends that demonstration projects combining public and private resources be funded to determine if innovative programs to fill the coverage gap can be successful on a large scale and replicated in other areas.

One replication problem the Working Group noted was that while a significant number of middle-income children need coverage, the number of children available for the insurance risk pool in any given area varies greatly across State and local jurisdictions. Because a large risk pool of children is needed to absorb the risk of a seriously-ill child, small numbers of children place insurers at greater risk of not covering costs. This increased risk results in higher premiums for parents and reduced benefits for children, as is the case with the Sacramento IV-D Kids program. Therefore, the Working Group includes as part of this recommendation that the demonstration projects include a strong element of cooperation with SCHIP as a means to expand the scope of dependent health coverage provided, geographic areas of coverage, numbers of children insured, and portability of health insurance coverage. A program that could combine the private-payer features of Sacramento's IV-D Kids pilot program with SCHIP's larger group of providers, comprehensive benefits, and low premiums could provide comprehensive medical coverage that ***seamlessly*** covers children, regardless of parents' income levels (Medicaid, SCHIP, or non-aided).

> *"[T]here are so many people who are not eligible now for medical coverage, who are not eligible for SCHIP, that there's got to be a large segment of the population that need a pool, and maybe a kids' pool would ... allow children to be covered."*
>
> **~R. Ann Fallon, Attorney at Law, Whiting, Fallon & Ross**

Another feature that the Working Group would like considered in these demonstrations is the placement of a medical support facilitator within the court or administrative unit handing the child support actions. The facilitator would communicate with the administrators of the various coverage options. One aspect of the demonstration would explore the different ways to structure the multi-layered communication to ensure that each child gets into the right coverage option and to determine the best procedures for communicating with the custodial and noncustodial parent.

Payment of premiums would most likely be made through wage assignment. But the demonstrations should explore whether the cost of premiums should vary depending on parent income. For example, if the noncustodial parent met income qualifications for the SCHIP coverage, the current requirement that the IV-D agency pursue the noncustodial parent for the full, unsubsidized cost of the insurance premium could be waived: that is, qualifying under SCHIP's income test would itself be prima facie evidence of a noncustodial parent's inability to pay a full premium. If the noncustodial parent did not qualify for fully-subsidized coverage under the SCHIP means test, a wage assignment for the full premium would be issued. However, because the overall pool of children would now include all children—those covered by SCHIP, Medicaid, and IV-D Kids—the "full premium" could be substantially less than the group rate secured by an independent "gap" program alone. If the noncustodial parent did not qualify under the SCHIP-based means test, then the noncustodial parent would be responsible for the unsubsidized portion of the premium.

The SCHIP provider pool should not be adversely affected by adding more children into the coverage pool. The children reached by the new coverage are not insured elsewhere, so crowd-out is not an issue under this plan. That is, an increase of children insured under a combined SCHIP-Medicaid-Gap Coverage Program will not result in a corresponding market reduction in another plan. Instead, children (and their parents) will be first-time and potentially long-term customers of the insurers who provide them with health care coverage. Also, the inclusion of additional children, accompanied by inexpensive consumer education about preventive care, could increase insurance company profitability while it improves children's health. See Recommendation 71.

Better Coordination of Policies and Programs

The mandate of the Working Group focuses the health care coverage spotlight on IV-D medical child support enforcement. This topic, however does not exist in isolation and it is subject to meaningful examination only if cast against the backdrop of the national health care landscape. It is extremely important that broad efforts to improve health policy continue to be

undertaken so that IV-D medical support efforts are not hampered by a lack of coordination and cooperation in the broader health care environment.

Recommendation 71 (Research and Demonstration)

The HHS should seek Congressional appropriation to fund demonstration projects for a minimum of three to five years to encourage states to adopt public-private partnership health care models for children who are eligible for IV-D services. The HHS should provide information to the States regarding how to establish a public-private model (such as Sacramento IV-D Kids) that is combined with SCHIP/Medicaid program to make private insurance available for individual children at a group rate. Model programs will have features such as the following:

- State IV-D Agencies will gain access to the SCHIP provider pool, making the SCHIP's benefits, including dental and vision, accessible to a pool of children eligible for child support services at the reduced rate created by the increased population pool.
- The target group will be children served by State child support enforcement agencies, regardless of income level, who do not have reasonable access to employer-provided insurance due to cost, access, continuity of coverage or other reasons.
- Facilitators for the Model program will be stationed in family law courts, who will enroll children for coverage at the time the order for support is entered. The facilitator will communicate with the third-party administrator, who will facilitate all subsequent transactions between the third-party SCHIP and the children.
- The efficacy of the court facilitator's role in the Model program will be evaluated separately and as part of the whole Model. The separate evaluation will focus on the facilitator's effectiveness in making families aware of various available health care programs and enrolling children in the most appropriate and cost-effective programs.
- If the noncustodial parent's income is higher than the SCHIP-based eligibility cut-off, a wage assignment for the full insurance premium will be issued. However, since the overall pool of children would include children covered by SCHIP, Medicaid, and the Model program, the "full premium" could be substantially less than the group rate secured by the IV-D Kids Program alone. If the noncustodial parent's income and assets make the children ineligible for SCHIP, then the noncustodial parent will be able to buy into the equivalent of the SCHIP program by paying the premium required under the Model program.
- Since the medical premium will be part of the child support order, a separate health care application process will not be needed.
- Coordinating the third-party administrators of the Model program and the SCHIP program will create a system that provides children with seamless health care coverage throughout the life of the order, regardless of changes in the parents' income levels.

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Building Better Partnership for Health Policy Oversight

The majority of the nation's health care coverage for children is provided through the employer community. Impediments to employer-sponsored coverage directly impact the extent to which children receive health coverage. The lack of coordination at the national level creates anomalies and confusion, contributes to unwillingness or inability to participate in or provide group health coverage, and promotes a litigious environment. This ultimately discourages provision of health coverage and increases health care costs, further exacerbating the uninsured problem.

The Working Group recommends that action be taken to convene two related working groups—a national policy and coordination group and a Federal legislative and regulatory group—to provide oversight on health care programs that affect children.

National Policy Coordination Group

The Working Group has been successful in exchanging ideas and developing solutions that reflect a partnership of diverse communities—government, business, parents, and advocates. We are recommending that this process be institutionalized to benefit future generations of children and families through the creation of a national health care policy coordination group.

Such a group would be able to help establish objectives for improved health care and to guide initiatives in furtherance of those objectives. The policy group could lead the effort to help establish national health care policies and objectives and to help establish priorities for health care needs. It would be comprised of various sectors involved in the health care field, such as government representatives at the State and Federal level, as well as industry groups representing the insurance industry,

Recommendation 72 (Federal Legislation)

The Administration should convene a national policy and coordination group that will act through the Federal agencies to provide oversight on health care programs that affect children. The policy group should establish a mechanism or process to encourage dialogue and ensure coordination on health care program issues, especially those impacting children. This process will ensure that interested groups, such as Child Support Enforcement, providers, and payers, help in developing and implementing national objectives concerning health care coverage for children. The group will help ensure that policies, objectives, guidelines, and regulations are consistent, and that these initiatives are designed with consideration for their impacts on all affected parties.

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employers, and business community. The charter of the policy group would include researching legislation and regulatory directives to determine if they present any conflicts to existing legislation (both at the State and Federal level), and to determine whether these directives would negatively impact health care costs. This group would evaluate whether a proposal will enhance the goal of any national health care policy that may be developed or will be counterproductive (that is, result in higher costs or hinder the effects of existing legislation.) This group would study the effects to assure that there are no resulting unintended consequences. See Recommendation 72.

Federal Regulatory Coordination Group

Piecemeal Federal legislation and/or regulatory agencies' requirements are not inherently ineffective, but often do create unintended consequences. The work of the broad interagency health care policy coordination group, discussed above, would be strengthened by the establishment of a Federal legislative and regulatory oversight group with specific responsibility to guide development and implementation of specific proposals within the context of the broad health policy environment. This oversight group would consist of representatives of HHS to represent medical and social issues, DOL to represent employment interests, and the Department of Treasury to represent interests related to tax implications and incentives and others as appropriate.

States should also be encouraged to develop such oversight groups. Numerous State programs and mandates have been

Recommendation 73 (Administrative Action)

All Federal and State regulatory agencies should develop mechanisms for reviewing proposed health care programs and mandates and incorporating programs and mandates for subsequent periodic review.

Review mechanisms should focus on:

- Research designed to obtain information about how proposed programs or mandates may conflict with existing programs or mandates, especially those that will impact children.
- Establish standards and goals for initiatives and mandates. For example, the number of uninsured children has been reduced by 20 percent (+/-).
- Periodically review established programs, in accordance with standards and goals, such as the goal of cost-effectiveness, and determine whether and to what extent programs are achieving their intended purposes. For example, child support enforcement agencies should determine whether the numbers of uninsured parents and children have been reduced or whether parents' obligations to provide health care coverage are being met.

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established to promote health care coverage of children. In many States there are multiple programs that overlap, including those that focus almost exclusively on children. Some form of family health coverage exclusively for children is available in all 50 States, but options for coverage are limited and prices vary widely between markets. States may develop their own tax incentives for health care coverage by employers and/or individuals but not understand how the incentives and State programs interact. Reviews of programs and other provisions at both the State and Federal level could be used to correct individual problems, clarify confusion and misunderstandings, and identify gaps in coverage or services. These findings should feed back into the deliberations of the broader policy coordination efforts. See Recommendation 73.

Containing Health Care Cost

Private family health coverage is a very cost-sensitive benefit, both for employers and employees. If efforts to expand private coverage for children and to enroll children in public health care programs when private coverage is not an option are to be successful, then all stakeholders, including the general public as taxpayers, need to be concerned about containing health care costs. The Working Group makes two recommendations, which it believes could have a long term positive impact on ensuring health care coverage for children; the first is on consumer education and preventive health care and the second is on the need for review of certain tax policies.

Consumer Education and Preventive Health Care

One cost containment strategy is to encourage consumer education and preventive health measures. Some programs already have been implemented successfully by civic groups and health care providers. For example, former Surgeon General C. Everett Koop, with Senator Robert Graham and HHS/HCFA, began promoting preventive health measures—from smoking

A Preventive Health Program in the Private Sector

Communication is key to promoting healthier lives, according to Linda Barnes, Director for Learning Services for Magic Valley (Idaho) Regional Medical Center, a regional county hospital serving an eight-county area. The hospital has implemented or participated in programs, such as the following: (1) safety education focused on children; (2) education on helping diabetics follow a healthy diet, which helps prevent costly hospitalization; (3) cardiac risk programs; (4) implementation of a diagnostic cardiac laboratory and cardiac rehabilitation (case management) program; and (5) free mammograms.

cessation to dieting and exercise—as important health care initiatives.

Community education programs could be established to help inform individuals of such matters as how the health care system works, how individuals and their demand for services affects delivery and costs, how to shop for health care, and how to assess appropriate levels of care. Fee schedules that allow "comparison shopping" could be published with respect to fees charged by physicians, clinics, hospitals, and other health care providers. Quality measures, such as health care outcomes or other factors that can be used to assess care and efficiencies accurately, could be made available to the public. Employees, employers, and other health plan sponsors can use such data for comparison shopping for the most cost-effective health care coverage. These types of efforts could help lower overall health cost, thus ensuring affordability for both employers and employees. 🗎 See Recommendation 74.

Review of Tax Policy

Favorable tax treatment can help reduce health care costs. Tax policy does not always seem consonant with health care policy. The Working Group recognized technical analysis of the tax laws would be beyond its scope, but believed such an objective analysis and a broad dissemination of funding to trade and bar associations, civic organizations, employer groups and other outlets, including the courts and IV-D agencies, would be important to the overall success of expanding health care coverage for children. Additionally, the Working Group identified specific examples of tax policies that seemed inconsistent with containing cost and promoting expansion of

🗎 Recommendation 74 (Technical Assistance)

The HHS should collaborate with the DOL, Department of Education, and other Federal agencies involved in health care, health care benefits, child support, and tax policies, to develop consumer education programs in order to help contain health care costs.

These consumer education programs could be promoted through tax incentives, grants, private foundation awards, and advocacy groups. The programs would focus on:

- The availability and types of health care programs available to children (and would target the parents of uninsured children)
- Consumer education that will allow the market to help control health care costs, such as developing literature on efficacy and cost of generic and brand-name drugs
- Civic health education, screening and preventive programs, civic risk education programs, and healthful life-styles programs.

private family health coverage that should be addressed.

Noncustodial parents are not the only adults who assume responsibility for providing dependent health care coverage. Sometimes stepparents, grandparents, or other family members step forward to fill the health care coverage gap for children. The current Internal Revenue Code, however, may not recognize the covered children as "dependents." It is the understanding of members of the Working Group that if an individual includes a child (who does not meet the Code definition of dependent) under coverage provided by the individual's employer, that individual may have to include the value of that child's coverage in gross income as reported for tax purposes.[6] This requirement may disadvantage a person who voluntarily enrolls a child in employer-provided coverage. A review such as the one contemplated by the Working Group could help clear up confusion regarding this and similar issues and make sure that families are not penalized for doing the "right thing" for children. See Recommendation 75.

Federal Tax Policy & Family Health Coverage

A parallel consideration in the mission to secure health care coverage for children residing in single-parent households is Federal tax policy. The size and availability of tax incentives for employers who provide dependent care benefits may drive their decision to offer family health coverage or to increase their contributions to premiums for such coverage. In addition, the Internal Revenue Code does not equitably account for expenditures on a child's health care needs by someone other than the custodial parent. As with employers, tax incentives may foster cooperation, particularly by the noncustodial parent.

The tax laws currently provide favorable treatment for costs incurred in medical treatment, but do not similarly treat costs incurred in activities that promote general health and well-being. The Working Group considered the example of smoking-cessation programs, which in the past were viewed as merely promoting general well-being, but which recently have been recognized as relating more directly to a

Recommendation 75 (Legislative Action)

Amend Tax Code to Extend Exclusion. The exclusion from income for health care costs under §105 and §106 should be extended to step-parents, grandparents, and other individuals who accept responsibility for obtaining or providing health care coverage for children, regardless of whether the child qualifies as a dependent of that individual under other provisions of the tax code.

medical condition. Such smoking cessation programs generally reduce health-risk factors. It is the Working Group's understanding that individuals generally may not deduct the cost of participating in such programs, and that an employee being reimbursed by an employer for such participation must include these amounts in gross income. A review, such as the one recommended by the Working Group, could help change tax policy to encourage health promotion as well as medical treatment.

An examination of the Internal Revenue Code is essential to fully assess these and other health care issues that can be addressed more clearly in the Code. Furthermore, the manner in which the Department of Treasury and the Internal Revenue Service address health care issues within their purview, such as COBRA conversion and HIPAA coverage, should also be evaluated to ensure they comport with over-arching health policy goals.

See Recommendation 76.

HIPAA
Health Insurance Portability and Accountability Act of 1996

COBRA
Consolidated Omnibus Budget Reconciliation Act of 1985

Continued improvement in health care coverage for children will not happen unless there are ongoing efforts to develop new strategies and new approaches that are responsive to the trends and changes in society-at-large. How to develop seamless coverage, so that child support-eligible children do not fall through the health care system's cracks, as they move between . different private coverage plans, between public and private coverage, and between types of public coverage is an important

Recommendation 76 (Administrative Action)

The Administration should establish an interagency group to evaluate the impact of tax and health care policy on the provision of children's health care coverage. This group, drawn from the Federal Departments of Treasury, Health and Human Services, and Labor should recommend and help develop tax laws that support the goal of securing health care coverage for all children.

- The interagency group should consider the impact of tax and health care policies upon health care costs, medical insurance costs, and children's access to health care services, with special emphasis on those children who live with a single parent.
- In order to reduce heath care costs and make medical insurance more affordable, the interagency group should consider granting tax incentives to preventive programs, such as health and safety programs.
- The interagency group also should evaluate tax and health care policies, with an aim to proposing legislation and developing regulations that promote individual awareness and responsibility for improving health and reducing health risks. The group might recommend Federal tax incentives for programs that promote proper diet, self-administered care, and exercise programs for diabetic children.

task. Undertaken jointly by the child support and public health communities and their private sector partners—employers, plan administrators, and the health insurance industry–research and demonstrations will help us identify and implement these new approaches. But just as important is the need for society to work together to develop new strategies and new approaches for containing health care costs. The overall growth in health care costs remains a constraint on efforts to increase health care coverage for the uninsured. Both the private and public sectors need to take leadership in promoting preventive health measures as important health care initiatives, enhancing employers' and employees' ability to provide health care coverage for children, and developing coordinated and consistent health care policy. Our children deserve no less, for they are our shared responsibility.

> *"Ask any insurer which kid he wants to insure when they become an adult: the one who's had access to health care all the way through or the one who hasn't... [T]he kids win, you win, and the insurers win... [T]he nation wins because we've reduced future health care costs."*
>
> **~Theodore R. Earl, Jr., Registered Representative, John Hancock, Inc.**

CHAPTER 8

Endnotes

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[1] *The Employer's Desk Guide to Child Support*, U.S. Department of Health and Human Services, Government Printing Office, Washington DC, (August 1999).

[2] 42 U.S.C. §452(f).

[3] 42 U.S.C. §1397bb(b)(3)E).

[4] O'Brien, Ellen and Judith Feder, *How Well Does the Employment-Based Health Insurance System Work for Low-Income Families?* Kaiser Commission on Medicaid and the Uninsured (September 1998); GAO, 1998; and Wheaton, Laura, "Noncustodial Fathers: To What Extent Do they Have Access to Employment Based Health Care Coverage?" The Urban Institute (forthcoming, June 2000).

[5] 1996 March-April Match File Current Population Survey. See data tabulations in APPENDIX D: Health Care Coverage for Child Support-Eligible Children, page A-32.

[6] Sections 105 and 106 of the Internal Revenue Code relate to the taxability of employer contributions to, and employee benefits received from, group health plans, and incorporate by reference the term "dependent" as defined in §152 of the Internal Revenue Code of 1986.

CHAPTER 9.
Conclusion/Postscript

The current medical support enforcement system is ineffective. Modeled on outdated assumptions, it does not reflect present realities that limit the availability, affordability, and stability of dependent health coverage. The recommendations contained in this report will greatly reduce impediments to medical support enforcement and establish a new paradigm, ensuring that all 21 million IV-D eligible children have accessible, comprehensive, and seamless health care coverage.

The Working Group recognizes that all proposed solutions cannot be implemented immediately. Nor can they be accomplished at all without the coordinated commitment of the public and private sectors—a partnership forged on our shared responsibility to America's children. Reforms will cost money. To some degree our recommendations require financial contributions from parents, employers, and the private insurance industry, in addition to government. They also require time, dedication, innovation, and flexibility, as these solutions are tested and even better ideas evolve from the research. Mostly, just as the Working Group developed consensus from disparate interests and legitimate competing concerns, so too must society forge a consensus to ensure that health care is a reality for all America's children.

Appendices

APPENDIX A: Next Steps - List of Recommendations Organized by Type/Category

Federal Legislation

Recommendation 6 (Federal Legislation)

(See page 3-7)

If the child is presently enrolled in either parent's private health care coverage and the coverage is accessible to the child, that coverage should be maintained. If, however, one of the parents has more appropriate coverage (as determined in accord with Recommendation 8 through Recommendation 11) and either parent requests that the child be enrolled in this plan, the decision maker shall determine whether or not to maintain the existing coverage based upon the best interests of the child.

Recommendation 13 (Federal Legislation)

(See page 3-20)

After determining that a child is not enrolled in private health care coverage, and that at least one parent could enroll the child in private coverage, the decision maker should determine which plan is most *appropriate* for the child (as defined in Recommendation 8) by evaluating the plan(s) in the following manner:

Step 1. Determine whether the child has access to the services provided under the coverage.

Step 2. Determine whether the cost of the coverage is reasonable.

Step 3. Determine whether the coverage is comprehensive.

Step 4. If, after following steps 1-3, the decision maker finds that only the *custodial* parent has accessible, affordable, and comprehensive coverage, that coverage should be ordered, with appropriate allocation of cost, as determined by the State child support guidelines. (See Recommendation 2)

If, after following steps 1-3, the decision maker finds that only the *noncustodial* parent has accessible, affordable, and comprehensive coverage, that coverage should be ordered, with appropriate allocation of cost, as determined by the State child support guidelines. (See Recommendation 2)

Step 5. If, after following steps 1-3, it is determined that accessible, affordable, comprehensive coverage is available to both parents, then coverage available to the custodial parent should be ordered unless (1) either parent expresses a preference for coverage available through the noncustodial parent; or (2) the noncustodial parent is already carrying dependent's coverage for other children, either under a child support order for those children or because the children reside in his current household, and the cost of contributing toward the premiums associated with the custodial parent's coverage is significant. If either of the exceptions applies, the decision maker should make an assessment of what is in the best interests of the child and order coverage accordingly.

If neither parent has family health coverage, see Recommendation 14 *and* Recommendation 15.

Recommendation 16 (Federal Legislation)

(See page 3-25)

To facilitate enrollment of eligible children in public coverage, Federal law should require State IV-D agencies to: (1) provide parents with information about the Medicaid and SCHIP programs, as well as any other subsidized coverage that may be available to the child; and (2) refer the family to the appropriate program for possible enrollment.

Recommendation 17 (Federal Legislation)

(See page 3-26)

Congress should amend §1920A of the Social Security Act to include IV-D agencies among the "qualified entities" that may enroll children in Medicaid for a presumptive eligibility period, based on preliminary information that indicates that the child is income-eligible for Medicaid.

Recommendation 19 (Best Practice, Federal Legislation)

(See page 3-28)

Part A (Best Practice): States should grant authority to the decision maker to order the noncustodial parent to contribute toward the State cost of providing coverage under Medicaid and SCHIP. Provided, however, no contribution should be ordered from any noncustodial parent whose net income (as defined by the State to determine Medicaid eligibility) is less than 133 percent of poverty.

Part B (Federal Legislation): Congress should amend §467 of the Social Security Act to provide that the amount the noncustodial parent may be ordered to contribute toward the monthly cost of coverage under Medicaid or SCHIP shall be the *lesser* of: (1) the estimated cost of enrolling the child in Medicaid or SCHIP; (2) five percent of the noncustodial parent's gross income; or (3) the amount indicated by a sliding fee schedule, developed by the State, which takes into account ability to pay and average Medicaid/SCHIP costs for dependent children.

Recommendation 20 (Federal Legislation)

(See page 3-31)

Congress should amend Title IV-D of the Social Security Act to preclude State IV-D agencies from attempting to recover Medicaid-covered prenatal, birthing, and perinatal expenses from the noncustodial parent.

Recommendation 35 (Federal Legislation)

(See page 4-11)

Congress should enact legislation requiring health care plans to send a copy of any COBRA notice related to a child's loss of health coverage to the State IV-D agency *if* the health care plan received any QMCSO, including the National Medical Support Notice for that child, from the IV-D agency.

Recommendation 42 (Federal Legislation)

(See page 4-14)

Congress should enact legislation that would allow Federal agencies to enroll Federal employees and their dependents in the Federal Employees Health Benefits Program without the employee's consent if the employee is ordered to provide such coverage for his or her dependent(s).

Recommendation 43 (Federal Legislation)

(See page 4-14)

Congress should enact legislation to allow the U.S. military to enroll its employees and their dependents in Tri-Care without the employee's consent if the employee is ordered to provide such coverage for his or her dependents.

Recommendation 44 (Federal Legislation)

(See page 5-5)

When the decision maker requires the custodial parent to provide coverage for the children, the parent should verify that the children have been enrolled within a reasonable time, to be determined by the State. When the child support enforcement agency provides enforcement services, and the children are not enrolled as ordered, the child support enforcement agency should take appropriate steps to enforce the order against the custodial parent. However, any notice that is sent to the parent should ask the custodial parent to contact the child support enforcement agency if she did not provide health care coverage because of some financial difficulty, a change in employment, other change in circumstances, and/or the noncustodial parent's failure to comply with an order that required him/her to pay a portion of the premium.

Recommendation 58 (Federal Legislation)

(See page6-16)

Congress should repeal §1902(a)(25)(F) of the Social Security Act to allow State Medicaid agencies to cost-avoid claims where the third party coverage is derived through a noncustodial parent's obligation to provide medical coverage.

Recommendation 62 (Federal Legislation)

(See page 6-21)

Congress should amend ERISA §701(f)(2)(A)(iii) to include children enrolled pursuant to a QMCSO among the categories of dependents who, if certain other requirements are met, must be given special enrollment rights.

Recommendation 63 (Federal Legislation)

(See page 6-23)

Provided that Congress makes the following changes to §1908 of the Social Security Act (42 U.S.C. §1396g-1), Congress should also amend §1908 to state explicitly that the laws it requires States to pass as a condition of participation in the Medicaid program apply to all children (regardless of whether they are eligible for assistance under the State Medicaid plan), and should amend §609 of ERISA to incorporate the requirements of the amended §1908. The necessary changes are:

- Clarify that a child who is in enrolled in a group health plan pursuant to a court or administrative order could be disenrolled under circumstances under which other dependent children would lose coverage (for example, elimination of family health coverage for all employees in the same business unit or job category).
- Amend §1908(a)(1) to provide that, if there is no QMCSO, a child would be enrolled only if the participant enrolls or consents to the enrollment of the child.

Recommendation 65 (Federal Legislation)

(See page 7-6)

Congress should amend Federal law to provide for 90 percent enhanced Federal Financial Participation to State IV-D agencies for a five-year period to facilitate the implementation of the

Title IV-D medical support requirements, contained in §401 of CSPIA 1998, and additional Federal requirements that result from the Working Group's recommendations. This funding may be capped.

Recommendation 66 (Federal Legislation)

(See page 7-8)

Congress should amend Federal law to require that the medical support incentive measure is developed in conjunction with the implementation of CSPIA 1998 §401 requirements and additional requirements that may be imposed by law or regulation, based on the recommendations of the Working Group. The measure should also take into account the findings of the research and demonstration grants undertaken by States and funded by HHS.

Recommendation 67 (Federal Legislation)

(See page 7-10)

Congress should amend Federal law to require HHS to publish the medical support performance incentive measure in final form within three years of the date the 90 percent FFP goes into effect. Implementation of the medical support performance incentive measure shall begin upon publication, including the collection and submission by the States to OCSE of all data necessary to calculate the measure. The medical support performance incentive measure shall be included in the calculation of incentive payments due States beginning 2 years after publication. This five-year time period shall run concurrent with that set forth in Recommendation 65 (Federal Legislation).

Recommendation 72 (Federal Legislation)

(See page 8-11)

The Administration should convene a national policy and coordination group that will act through the Federal agencies to provide oversight on health care programs that affect children. The policy group should establish a mechanism or process to encourage dialogue and ensure coordination on health care program issues, especially those impacting children. This process will ensure that interested groups, such as Child Support Enforcement, providers, and payers, help in developing and implementing national objectives concerning health care coverage for children. The group will help ensure that policies, objectives, guidelines, and regulations are consistent, and that these initiatives are designed with consideration for their impacts on all affected parties.

Recommendation 75 (Legislative Action)

(See page 8-15)

Amend Tax Code to Extend Exclusion: The exclusion from income for health care costs under §105 and §106 should be extended to step-parents, grandparents, and other individuals who accept responsibility for obtaining or providing health care coverage for children, regardless of whether the child qualifies as a dependent of that individual under other provisions of the tax code.

Federal Regulation

Recommendation 1 (Federal Regulation)

(See page 3-3)

The HHS should require each State to maximize the enrollment of children in appropriate health care coverage; the first recourse should be appropriate private coverage of either parent. *("Appropriate coverage" is defined in Recommendation 8.)*

Recommendation 2 (Federal Regulation)

(See page 3-4)

Each State's child support guidelines should show how the cost of health care coverage will be allocated between the parents.

Recommendation 3 (Federal Regulation)

(See page 3-5)

Each State should develop mechanisms that require both parents to disclose information about actual and potential private health care coverage in order to help the decision maker determine whether private coverage is available to either parent.

Recommendation 4 (Federal Regulation)

(See page 3-5)

States should use existing automated databases providing information about private health care coverage available through employers or use insurers' databases. Such databases need not contain information about the types of benefits offered, only whether dependent coverage is offered by an employer. For further details about the development of or modification to such databases, see Recommendation 64.

Recommendation 8 (Federal Regulation)

(See page 3-10)

If a child is not enrolled in private coverage, the decision maker shall determine whether one or both parents are able to obtain *appropriate* coverage for the child based on three factors: (1) comprehensiveness of the plan, (2) access to services, and (3) affordability. Each factor should be assessed individually and then considered together in accord with Recommendation 13.

If a child has special needs, the decision maker should consider this circumstance in conjunction with the needs of the primary plan member and other dependents (see Recommendation 12).

Coverage is *comprehensive* if it includes at least medical and hospital coverage; provides for preventive, emergency, acute, and chronic care; and imposes reasonable deductibles and co-payments. In determining which coverage is more comprehensive when both parents have such coverage, the decision maker should consider the following: basic dental coverage, orthodontics, eyeglasses, mental health services, and substance abuse treatment.

Coverage is *accessible* if the covered children can obtain services from a plan provider with reasonable effort by the custodial parent. When the only health care option available through the noncustodial parent is a plan that limits service coverage to providers within a defined geographic area, the decision maker should determine whether the child lives within the plan's service area. If the child does not live within the plan's service area, the decision maker should determine whether the plan has a reciprocal agreement that permits the child to receive coverage at no greater cost than if the child resided in the plan's service area. The decision maker should also determine if primary care is available within the lesser of 30 minutes or 30 miles of the child's residence. If primary care services are not available within these constraints, the coverage should be deemed inaccessible. In lieu of the 30 miles/30 minutes standard, States may adopt an alternative standard for time and distance, such as the standard that the State uses to administer programs such as Medicaid managed care services or to regulate managed care provider networks.

In determining accessibility, the decision maker should also assess whether one can reasonably expect the coverage to remain effective for at least one year, based on the employment history of the parent who is to provide the coverage.

Reasonable cost should be assessed based on Recommendation 9 through Recommendation 11.

APPENDIX A

Recommendation 9 (Federal Regulation)

(See page 3-14)

The Federal regulation that deems all employment-related or group-based coverage to be reasonable in cost should be replaced with a standard based on the cost of coverage relative to the income of the parent who provides the coverage. Except as noted in Recommendation 10 and Recommendation 11, if the cost of providing private coverage does not exceed five percent of the gross income of the parent who provides coverage, then the cost should be deemed reasonable.

Recommendation 21 (Federal Regulation)

(See page 3-32)

The States should give the decision maker authority to order either or both parents to contribute toward: (1) the cost of any co-payments, deductibles, or costs associated with the ordered health care coverage; and (2) any uncovered medical expenses incurred by the child.

Recommendation 22 (Federal Regulation)

(See page 3-33)

To the extent that unreimbursed costs are not included in the State's basic child support guideline formula, those costs should be apportioned *pro rata* between the parties.

Recommendation 29 (Federal Regulation)

(See page 4-8)

HHS and DOL should publish the National Medical Support Notice in final form no later than September 1, 2000 to allow States sufficient time to implement automated processes by October 1, 2001.

Recommendation 36 (Federal Regulation)

(See page 4-12)

If some or all of the options under a health care plan are limited to specified geographic service areas, such as those covered by specific zip codes, then:

- The plan administrator should indicate that geographic restrictions apply and should provide information that would make it possible for the IV-D agency to determine whether the coverage is accessible to a child (see Recommendation 8).
- The plan administrator should be instructed to enroll the child—unless the IV-D agency requests that a child not be enrolled—even if the only available plan coverage is geographically limited and the child is outside the plan's service area.

Recommendation 37 (Federal Regulation)

(See page 4-12)

If the plan administrator cannot determine a child's zip code or location from the Notice because a Substitute Official's address is used, the plan administrator should be instructed to contact the IV-D agency and provide sufficient information to permit the agency to decide whether or not the coverage is accessible as defined in Recommendation 8.

Recommendation 39 (Federal Regulation)

(See page 4-13)

If an employee is in a waiting period that will expire within 90 days after the receipt date of the Notice, then the plan administrator should: (1) determine whether the Notice is a qualified order, and (2) notify the IV-D agency and the parents of the date on which coverage will begin.

If the waiting period expires more than 90 days after the receipt of the Notice, or if the duration of the waiting period is determined by some measure other than the passage of time (for example, the completion of a certain number of hours worked), then once the plan administrator has determined that the Notice is a qualified order, the plan administrator would describe the waiting period on the portion of the Notice returned to the IV-D agency (Part B), and the employer would notify the plan administrator when the employee is eligible to enroll in the plan and when a NMSN is in effect with respect to one or more children of the employee. The plan administrator then notifies both parents.

Recommendation 45 (Federal Regulation)

(See page 5-6)

The Secretaries of HHS and DOL should request the Department of Commerce to review the current provisions of the Consumer Credit Protection Act, which specifies limits on wage garnishment for family support payments, 15 U.S.C. §167(b)(2)(A) and (B). The Department should clarify whether the lower wage garnishment applies only to individuals who have an order to support a spouse or one or more children outside of their households and are also supporting a spouse and/or child within their household.

Recommendation 49 (Federal Regulation)

(See page 5-11)

A Federal policy on the priority of allocation by employers of funds collected through wage withholding should be promulgated. Employers should first attribute withheld funds to current cash support (alimony and child support), then to health care premiums and other current medical support, then to arrears (cash or medical) and then to other obligations. Decision makers should have the flexibility under State law to deviate on a case-by-case basis and provide that health care premiums will be paid first when that is in the best interest of the child.

Recommendation 52 (Federal Regulation)

(See page 6-7)

HCFA should issue SCHIP regulations that allow a child to be eligible for SCHIP if the child is enrolled in a group health plan but does not have reasonable access to care under that plan.

Recommendation 61 (Federal Regulation)

(See page 6-21)

The DOL should issue regulation(s) that make it clear that ERISA §701(f)(1)(C)(ii) (special enrollment for individuals losing other coverage) permits a child to be specially enrolled in a new plan, after prior coverage obtained through a Qualified Medical Child Support Order (QMCSO) is terminated, if the coverage ends during the period covered by the order or at the end of the period covered by the order. This would permit a child to enroll in other available coverage provided by either parent, if coverage is terminated for some reason related to the medical support order.

Recommendation 64 (Federal Regulation)

(See page 6-24)

The term "family health coverage" should be defined in regulations and guidelines to include health coverage that provides benefits to dependents, including a dependent-only policy.

Federal Guidance

Recommendation 5 (Federal Guidance)

(See page3-6)

To further expand the ability of IV-D agencies to obtain information about actual and potential health care coverage available to both parents, OCSE should inform these agencies that §466(c)(1)(C) gives the agencies the authority to request health care benefits information from employers before they establish a medical support order. In conjunction with this, the DOL should inform plan administrators subject to ERISA that they must respond to such IV-D requests when they are made for the purpose of drafting a Qualified Medical Child Support Order (QMCSO). (See Recommendation 29.)

Recommendation 12 (Federal Guidance)

(See page 3-16)

The decision maker must consider a child's special medical needs when deciding which form of private or public coverage is appropriate under Recommendation 8 through Recommendation 11. HHS should identify governmental agencies that are currently studying issues involving children with special needs and should coordinate with these agencies in the development of a common definition of "special needs" children. HHS should provide guidance to State IV-D agencies on how best to use the decisionmaking matrix set out in *Recommendation 13* when a special needs child is involved.

HCFA should require Medicaid agencies to identify whether there is a special needs child in any case they refer to the IV-D program pursuant to the child support cooperation requirement of the Medicaid program.

Recommendation 18 (Federal Guidance)

(See page 3-26)

Provided that Congress amends the Social Security Act to allow State IV-D agencies to presumptively enroll children in Medicaid, OCSE and HCFA should strongly encourage all States to exercise this option or to take other steps to facilitate Medicaid enrollment, including placing Medicaid or SCHIP staff in IV-D offices, providing application forms to potentially eligible families, and arranging eligibility appointments.

Recommendation 25 (Federal Guidance)

(See page [illegible]34)

To facilitate implementation of Recommendation 24, the DOL and HHS should develop model language regarding health care coverage for inclusion in child support orders. The model language, which would not be mandatory, would alert attorneys, child support workers, and court personnel to common issues that should be addressed in such orders.

Recommendation 27 (Federal Guidance)

(See page 4-4)

DOL and HHS should: (1) make it clear that the Notice is deemed to be a Qualified Medical Support Order only if issued by IV-D agencies, and (2) explain how the QMCSO process works for private parties. (See Recommendation 25)

Recommendation 33 (Federal Guidance)

(See page 4-9)

The DOL should inform employers, insurers, and plan administrators that when a noncustodial parent carries health care coverage for a child, and the provider of services or the custodial parent of such child submits the claim, 42 USC §1396g(a)(5) requires the insurer to pay the person or entity that submits the claim to the same extent the employee is entitled to be paid.

Recommendation 40 (Best Practice/Guidance/Technical Assistance/Notice Comments)

(See page 4-14)

Where the court determines that a pattern of misappropriation of insurance payments exists, the court may, at its discretion, order the insurer to pay all claims for reimbursement directly to the provider of services. This provision should be binding on all parties.

Technical Assistance/Education

Recommendation 26 (Technical Assistance)

(See page 3-34)

Following adoption of the recommendations of the Medical Child Support Working group, DOL and HHS should provide training and technical assistance to courts to facilitate implementation of the recommendations, particularly those relating to the decision-making matrix and enrolling children in Medicaid and SCHIP.

Recommendation 28 (Technical Assistance)

(See page 4-5)

The DOL and HHS should collaborate with State IV-D agencies and organizations representing employers, plan administrators, and payroll agents to develop automated State IV-D systems that can produce the National Medical Support Notices and distribute these Notices and their responses to affected parties.

Recommendation 30 (Education/Technical Assistance)

(See page 4-9)

The DOL and HHS should develop strategies to educate and reach out to all categories of constituents who have a need for, or interest in, the National Medical Support Notice, including the following categories of constituents:

- American Bar Association

- State and Local Bar Associations
- State Courts
- Private Attorneys
- American Payroll Association
- Child Support Organizations (NCSEA, ERICSA, WICSEC)
- National Coordinating Committee for Multi-employer Plans
- AFL-CIO
- International Foundation of Employee Benefit Plans
- Association of Private Pension and Welfare Plans
- ERISA Industry Committee
- Society of Professional Benefit Administrators
- National Association of Insurance Commissioners
- Society for Human Resource Management
- Native American Tribes
- Federal Government
- Military
- Faith-Based Organizations
- State and local governments

Recommendation 31 (Education and Technical Assistance)

(See page 4-9)

DOL and HHS should reach out to courts and administrative authorities to educate them regarding the Notice and the health coverage data required for completion.

Recommendation 32 (Education/Technical Assistance)

(See page 4-9)

The DOL and HHS should draft an easy-to-understand booklet similar to HHS's *The Employer's Desk Guide to Child Support* and DOL's booklet on *Qualified Domestic Relations Orders (QDRO) under ERISA*. The booklet should explain the National Medical Support Notice and the

APPENDIX A

DOL's views and interpretations of ERISA's Qualified Medical Child Support Order (QMCSO) provisions.

Recommendation 34 (Technical Assistance)

(See page 4-10)

The DOL and HHS should develop and make available to States a suggested model "Notice of Release" that State IV-D agencies may issue to employers when a noncustodial parent's obligation to provide health care coverage terminates.

Recommendation 40 (Best Practice/Guidance/Technical Assistance/Notice Comments)

(See page 4-14)

Where the court determines that a pattern of misappropriation of insurance payments exists, the court may, at its discretion, order the insurer to pay all claims for reimbursement directly to the provider of services. This provision should be binding on all parties.

Best Practice

Recommendation 7 (Best Practice)

(See page 3-9)

DOL and HHS should request the NAIC to encourage insurance providers with limited coverage areas to enter coordination agreements under which children who are covered under a geographically inaccessible plan can obtain services from a plan that is geographically accessible to them. Child support enforcement should publicize the availability of such plans and encourage States to take into account the possibility that out-of-area coverage may be available when assessing whether a particular plan is accessible to the child.

Recommendation 10 (Best Practice)

(See page 3-15)

No parent whose net income is at or below 133 percent of the Federal poverty level should be ordered to provide private coverage, unless that parent has access to private coverage that does not require an employee contribution to obtain coverage.

Recommendation 11 (Best Practice)

(See page 3-15)

No parent whose resident child is covered by Medicaid, based on that parent's income, should be ordered to provide private coverage, unless the parent has access to private coverage that does not require an employee contribution to obtain coverage.

Recommendation 14 (Best Practice)

(See page 3-22)

When neither parent has access to private health care coverage at reasonable cost but a step-parent does, enrolling the children in the step-parent's coverage should be considered *under certain conditions*. These conditions are: (a) the coverage is accessible to the children; (b) the step-parent is willing to provide such coverage; and (c) there are no employer/insurer constraints for enrollment of the child.

When these conditions are met, the parent who is married to the step-parent should be ordered to provide health care coverage for the children. The order should specify that this obligation may be met by enrolling the children in the step-parent's health care coverage. Moreover, the order must make it clear that if the obligated parent and the step-parent later commence proceedings for a separation or divorce, the obligated parent has responsibility for obtaining information about the cost and availability of COBRA coverage for the children and enrolling the children in this coverage. The order should also specify that if COBRA (or other) coverage is not available or affordable, the obligated parent must immediately seek modification of the medical provisions of the child support order. As an alternative, the custodial parent should seek publicly-funded coverage in order to minimize any lapse in coverage for the children.

Recommendation 15 (Best Practice)

(See page 3-24)

When neither parent can provide comprehensive, accessible, affordable private health care coverage, the decision maker should explore the possibility of providing coverage to the child through Medicaid or the SCHIP. If the child is ineligible for Medicaid or SCHIP, the decision maker should explore whether there is any available lower-cost, child-only plan, such as Sacramento IV-D Kids.

Recommendation 19 (Best Practice, Federal Legislation)

(See page 3-28)

Part A (Best Practice): States should grant authority to the decision maker to order the noncustodial parent to contribute toward the State cost of providing coverage under Medicaid and SCHIP. Provided, however, no contribution should be ordered from any noncustodial parent whose net income (as defined by the State to determine Medicaid eligibility) is less than 133 percent of poverty.

Part B (Federal Legislation): Congress should amend §467 of the Social Security Act to provide that the amount the noncustodial parent may be ordered to contribute toward the monthly cost of coverage under Medicaid or SCHIP shall be the *lesser* of: (1) the estimated cost of enrolling the child in Medicaid or SCHIP; (2) five percent of the noncustodial parent's gross income; or (3) the amount indicated by a sliding fee schedule, developed by the State, which takes into account ability to pay and average Medicaid/SCHIP costs for dependent children.

Recommendation 23 (Best Practice)

(See page3-33)

Since the extent of unreimbursed costs is unknown at the time an order is established, each State should develop protocols that permit the court or administrative agency to reduce such expenses to a judgment based on the language of the order. These protocols should include time limits for the parent who has paid the expenses to claim reimbursement and time limits for the obligated parent to pay these expenses, as well as simple pro se procedures for making or contesting such claims. The protocols should also include procedures to enforce collection from the noncustodial parent.

Recommendation 24 (Best Practice)

(See page 3-34)

State child support guidelines should require that the medical support provisions of a child support order for private or public health care coverage clearly explain the obligation of each parent in meeting the child's health care needs. Although not necessary to be qualified under §609(a) of ERISA, orders should address, as fully as possible, each of the following issues:

- The party (custodial or noncustodial parent) responsible for obtaining public or private health care coverage
- The type of coverage to be obtained

- The cost of premiums and the manner in which each parent will contribute to those premiums
- The type of uncovered expenses for which the parties will share costs
- The specific manner in which each parent will contribute to the cost of uncovered expenses
- The designation of primary and secondary coverage in any case in which both parties are to provide health care coverage
- The circumstances under which the obligation to provide health care coverage for the child will shift from one parent to the other

Recommendation 38 (Best Practice)

(See page 4-12)

In situations in which the IV-D agency is advised that a choice is required with regard to plan options, the agency should do the following:

- If there is a Medicaid assignment in effect, the IV-D agency should consult with the custodial parent and the Medicaid agency, review the State's treatment of coverage under child support guidelines, choose the appropriate option consistent with the best interests of the child, and notify the plan.
- If there is no Medicaid assignment in effect, the IV-D agency should contact the custodial parent regarding the options, review such options in light of the State's treatment of coverage under the child support guidelines, ascertain the custodial parent's choice, and notify the plan.

Recommendation 40 (Best Practice/Guidance/Technical Assistance/Notice Comments)

(See page 4-14)

Where the court determines that a pattern of misappropriation of insurance payments exists, the court may, at its discretion, order the insurer to pay all claims for reimbursement directly to the provider of services. This provision should be binding on all parties.

Recommendation 46 (Best Practice)

(See page 5-7)

The current Federal wage-withholding limits should be maintained, but the Federal OCSE should advise the States that they can set lower limits, as long as they are not so low that they make it impossible to order the parent to provide health care coverage, in addition to child support, when it is available at reasonable cost.

Recommendation 47 (Best Practice)

(See page 5-8)

In any case where the amount of the parent's current child support payments exceeds Federal wage withholding limits, the decision maker should examine the calculation of the noncustodial parent's disposable income to determine whether the parent is reducing their disposable income through excessive withholding or other reductions in gross income that are not contemplated by the Consumer Credit Protection Act (CCPA).

Recommendation 48 (Best Practice)

(See page 5-9)

If the cost of providing private health care coverage increases a parent's child support obligation so that the amount exceeds Federal wage-withholding limits, the decision maker should have the authority to direct the custodial parent to apply for the Medicaid or SCHIP. If the child is found eligible, the decision maker may require the noncustodial parent to contribute toward the cost of coverage consistent with Recommendation 19.

Recommendation 55 (Best Practice)

(See page 6-11)

State child support enforcement and SCHIP agencies should establish effective ways of communicating with each other.

Recommendation 56 (Best Practice)

(See page 6-12)

In IV-D cases, when coverage is provided through Medicaid or SCHIP and information provided by the parties or obtained through New Hire Reporting indicates that private dependent health care coverage may now be available, it should be determined whether that coverage is appropriate for the child (as defined in Recommendation 8). If private dependent health care coverage is available and appropriate, the order should be modified as needed and a National Medical Support Notice should be sent to the employer and the child should be enrolled.

Research and Demonstration

Recommendation 68 (Research and Demonstration)

(See page 7-11)

HHS should study the savings and cost avoidance to the Medicaid program when IV-D secures and enforces a medical child support order for private insurance for Medicaid-eligible children.

HHS should also study alternate methodologies to supplement funding for the child support enforcement program based on such Medicaid program savings and avoided costs. If HHS does not have sufficient funds to meet the cost of such a study, it should seek an additional appropriation from Congress.

Recommendation 69 (Research and Demonstration)

(See page 8-4)

The Federal OCSE should conduct a study of the 11 States that ask employers to submit health care coverage information as part of their New Hire Reporting process. The study should analyze the costs and benefits of these efforts from the point of view of employers and States, consider the privacy issues raised by such an information exchange, and identify any precautions taken to protect the privacy of case participants. The results shall be communicated to the States and to the Congress.

If HHS does not have sufficient resources available to fund these studies and/or demonstration projects, the agency should seek an additional appropriation from Congress.

Recommendation 70 (Research and Demonstration)

(See page 8-6)

HHS should undertake projects that will examine various aspects of the intersections of child and medical support enforcement. These projects will encourage States to implement the Working Group's recommendations and promote further innovations to expand health care coverage for children. The projects may be, but should not be limited to, §1115 demonstrations and Child Support Enforcement State program improvement grants projects. These grants might examine issues such as:

- States' efforts to coordinate health care coverage availability between the Child Support, Medicaid, TANF, and SCHIPs programs
- Best practices in establishing and enforcing private family health coverage
- How automation/technologies can be used to improve medical child support enforcement and save tax dollars
- States' creative use of cross-program funding to promote medical support enforcement including, but not limited to, SCHIP block grant funds, PRWORA-related Medicaid matching funds, Federal TANF or States' maintenance of effort funds (MOE), and other block grant funds

- The availability of private family health coverage to IV-D families with an emphasis on access, cost, and comprehensiveness of family health coverage
- State-specific demographic and economic variables that impact performance and States' ability to improve medical support enforcement performance

If HHS does not have sufficient resources available to fund these studies and/or demonstration projects, the agency should seek an additional appropriation from Congress.

Recommendation 71 (Research and Demonstration)

(See page 8-10)

The HHS should seek Congressional appropriation to fund demonstration projects for a minimum of three to five years to encourage states to adopt public-private partnership health care models for children who are eligible for IV-D services. The HHS should provide information to the States regarding how to establish a public-private model (such as Sacramento IV-D Kids) that is combined with SCHIP/Medicaid program to make private insurance available for individual children at a group rate. Model programs will have features such as the following:

- State IV-D Agencies will gain access to the SCHIP provider pool, making the SCHIP's benefits, including dental and vision, accessible to a pool of children eligible for child support services at the reduced rate created by the increased population pool.
- The target group will be children served by State child support enforcement agencies, regardless of income level, who do not have reasonable access to employer-provided insurance due to cost, access, continuity of coverage or other reasons.
- Facilitators for the Model program will be stationed in family law courts, who will enroll children for coverage at the time the order for support is entered. The facilitator will communicate with the third-party administrator, who will facilitate all subsequent transactions between the third-party SCHIP and the children.
- The efficacy of the court facilitator's role in the Model program will be evaluated separately and as part of the whole Model. The separate evaluation will focus on the facilitator's effectiveness in making families aware of various available health care programs and enrolling children in the most appropriate and cost-effective programs.
- If the noncustodial parent's income is higher than the SCHIP-based eligibility cut-off, a wage assignment for the full insurance premium will be issued. However, since the overall pool of children would include children covered by SCHIP, Medicaid, and the Model program, the "full premium" could be substantially less than the group rate secured by the IV-D Kids Program alone. If the noncustodial parent's income and assets make the children ineligible for SCHIP, then the noncustodial parent will be able to buy into the equivalent of the SCHIP program by paying the premium required under the Model program.
- Since the medical premium will be part of the child support order, a separate health care application process will not be needed.

- Coordinating the third-party administrators of the Model program and the SCHIP program will create a system that provides children with seamless health care coverage throughout the life of the order, regardless of changes in the parents' income levels.

Administrative Action

Recommendation 54 (Administrative Action)

(See page 6-10)

The Secretary of HHS should convene a Working Group to develop protocols for implementing the recommendations concerning the enrollment of IV-D children in public rather than private health care coverage, particularly in interstate cases. This group should be comprised of staff from OCSE, HCFA, the Office of the Secretary, State Child Support, Medicaid, and SCHIP agencies as well representatives of other appropriate agencies and the courts.

Among the tasks of this Working Group should be: (1) determining the feasibility and advisability of developing and mandating the use of a standard notification system to transmit information between the State courts, child support enforcement agencies, and Medicaid and SCHIP agencies; (2) assessing the feasibility of each State creating a IV-D/Medicaid/SCHIP database to facilitate a standardized system for information exchange; and (3) exploring the possibility of administrative simplification between the IV-D, Medicaid, and SCHIP programs.

Recommendation 73 (Administrative Action)

(See page 8-12)

All Federal and State regulatory agencies should develop mechanisms for reviewing proposed health care programs and mandates and incorporating programs and mandates for subsequent periodic review.

Review mechanisms should focus on:

- Research designed to obtain information about how proposed programs or mandates may conflict with existing programs or mandates, especially those that will impact children.

- Establish standards and goals for initiatives and mandates. For example, the number of uninsured children has been reduced by 20 percent (+/-).

- Periodically review established programs, in accordance with standards and goals, such as the goal of cost-effectiveness, and determine whether and to what extent programs are achieving their intended purposes. For example, child support enforcement agencies should determine whether the numbers of uninsured parents and children have been reduced or whether parents' obligations to provide health care coverage are being met.

Recommendation 76 (Administrative Action)

(See page 8-16)

The Administration should establish an interagency group to evaluate the impact of tax and health care policy on the provision of children's health care coverage. This group, drawn from the Federal Departments of Treasury, Health and Human Services, and Labor should recommend and help develop tax laws that support the goal of securing health care coverage for all children.

- The interagency group should consider the impact of tax and health care policies upon health care costs, medical insurance costs, and children's access to health care services, with special emphasis on those children who live with a single parent.
- In order to reduce heath care costs and make medical insurance more affordable, the interagency group should consider granting tax incentives to preventive programs, such as health and safety programs.
- The interagency group also should evaluate tax and health care policies, with an aim to proposing legislation and developing regulations that promote individual awareness and responsibility for improving health and reducing health risks. The group might recommend Federal tax incentives for programs that promote proper diet, self-administered care, and exercise programs for diabetic children.

APPENDIX B: Glossary

Beneficiary

A person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder. (ERISA §3(8), 29 USC 1002(8)).

Child support-eligible Children

Children whose parents have divorced, separated, or decided not to marry or live together. Not all child support-eligible children live in single-parent households; about 20 percent live in married step-parent families. Some child support-eligible children live with neither parent, staying instead with a guardian or in placement through foster care.

Cost Avoidance

A method of avoiding payment of Medicaid claims when other insurance resources are available to the Medicaid beneficiary. Whenever the Medicaid agency is billed first, claims are denied and returned to the provider who is required to bill and collect from liable third parties. Cost avoidance also includes payment avoided when the provider bills the third party first.

Custodial Parent

Person with legal custody and with whom the child lives; may be parent, other relative, or someone else. Sometimes called obligee.

Group Health Plan

An employee welfare benefit plan that provides medical, surgical, hospital, or other health care benefits to participants or beneficiaries directly or through insurance, reimbursement, or otherwise (ERISA §607(1), 29 USC 1167(1)).

Guidelines

A standard method for setting child support obligations based on the income of the parent(s) and other factors as determined by State law.

IV-D Program

The Federal child support enforcement program, as established under Part D of Title IV of the Social Security Act. The IV-D program provides Federal funds to State Child Support Enforcement services operating under the Federal IV-D statute, regulations, and rules. Individuals who are receiving public assistance are required to cooperate with the IV-D program to establish and enforce a child support order. Individuals who are not receiving public assistance may participate in the IV-D program by completing an application, and may be required to pay a nominal application fee, no greater than $25.

IV-D Child Support Orders

Child support orders that are enforced by the State child support enforcement agency that must follow the requirements of Title IV-D of the Social Security Act.

Insured Plan

An employee welfare benefit plan under which benefits are provided through a contract or policy between the plan and an insurance company, HMO, or similar entity. The policies or contracts through which such plans provide benefits, as well as the insurance company, HMO or similar entity, are subject to State insurance laws.

Liable Third Party

Any individual, entity, or program that is, or may be, liable to pay all or part of the medical cost of any medical assistance furnished to a beneficiary under the approved State plan. This includes a group health plan as defined in §607(a) of ERISA, a service benefit plan, and a health maintenance organization.

Medicaid

A jointly-funded, Federal-State health insurance program for certain low-income and needy people. It covers approximately 36 million individuals including children, the aged, blind and/or disabled, and people who are eligible to receive Federally-assisted income maintenance payments.

Medical Child Support Order

A judgment, decree, or order issued by a court or administrative agency, including an administrative notice issued by such an agency, which has the force and effect of law, that provides for child support with respect to a child of a participant in a group health plan or provides for health benefit coverage to such child and relates to benefits under such plan. Generally, a "medical child support order" is the medical support component of a broader order for child support. (ERISA § 609(a)(2)(B), 29 USC § 1169(a)(2)(B))

Medical Support

Legal provision for payment of medical and dental bills. Can be either family health coverage or cash medical support. Note: States vary widely on what type of medical bills are included in this definition.

Multiemployer Plan

A plan to which more than one employer is required to contribute that is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations (generally, unions) and more than one employer. Such plans are also subject to certain rules of the Labor Management Relations Act. They are established and maintained pursuant to a joint board of trustees that is composed of equal numbers of employer and union trustees. Generally, contributions are made by employers pursuant to a formula contained in the collective bargaining agreement(s) based on the number of hours worked by union employees of the signatory employers. (ERISA §3(38)(A), 29 USC 1002(37)(A))

Noncustodial Parent

Parent who does not have primary custody of a child. Sometimes called obligor. Also known as "participant" for family health coverage purposes.

Order

Direction of a magistrate, judge, or properly empowered administrative officer.

Participant

An employee or former employee of employer, or a member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan that covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit. (ERISA §3(7), 29 USC 1002(7))

Pay and Chase

A method used in which Medicaid pays the beneficiary's medical bills and then attempts to recover from liable third parties.

Plan Administrator

The administrator of a plan is the person specifically so designated by the plan's organizational documents. If no administrator is specifically designated, then the administrator of the plan is the plan's sponsor. The plan administrator has several specific responsibilities under ERISA with respect to plan administration. (ERISA §3(16)(A), 29 USC 1002(16)(A))

Plan Fiduciary

ERISA generally defines a fiduciary to include someone with discretionary authority with respect to the administration of a plan, or the management of a plan or its assets. (ERISA §3(21), 29 USC 1002(21))

Plan Sponsor

For a plan that is established or maintained by an employer or employee organization, the sponsor is the employer or employee organization. For a plan that is established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the sponsor is the joint board or trustees or similar group of representatives of the parties who establish or maintain the plan. (ERISA §3(16)(B), 29 USC 1002(16)(B))

Preemption

In general, the doctrine that certain matters, either implicitly or by explicit expression of Congress, are of such a national, as opposed to local, character, that Federal laws supercede or take precedence over State laws. ERISA has a very broad explicit preemption of any State law that "relates to" an employee benefit plan, whether or not the State law conflicts with ERISA. (ERISA §514(a), 29 USC 1144(a))

Qualified Domestic Relations Order (QDRO)

A domestic relations order which creates or recognizes the existence of an alternate payee's right to receive, or assigns to an alternate payee the right to receive, all or a portion of the benefits payable with respect to a participant under a pension plan, and that includes certain information and meets certain other statutory requirements. An alternate payee is a spouse, former spouse, child, or other dependent of the participant. (ERISA §206(d)(3), 29 USC 1056(d)(3))

Qualified Medical Child Support Order (QMCSO)

A medical child support order which creates or recognizes the existence of an alternate recipient's right to receive benefits for which a participant or beneficiary is eligible under a group health plan, and that includes certain information and meets certain other statutory requirements. An alternate recipient is a child of a participant who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to the participant. (ERISA §609(a)(2), 29 USC 1169(a)(2))

Self-Insured Plan

An employee welfare benefit plan under which all benefits are paid either from the general assets of the sponsor of the plan, or from a trust into which the sponsor and/or participants have made contributions. Such plans generally are exempt from State law.

State Children's Health Insurance Programs (SCHIP)

The Balanced Budget Act of 1997 created a new children's health insurance program under Title XXI of the Social Security Act which enables States to initiate and expand health insurance for uninsured children with family incomes too high for Medicaid but too low to afford private family coverage. The law allows States to expand coverage for children through a separate child health insurance program, through the Medicaid program, or through a combination of these programs.

Temporary Assistance for Needy Families (TANF)

Time-limited assistance payments to poor families. The TANF program provides parents with job preparation, work, and support services to help them become self-sufficient.

Uniform Reciprocal Enforcement Of Support Act And Uniform Interstate Family Support Act (URESA and UIFSA)

Laws enacted at the State level that provide mechanisms for establishing and enforcing support obligations when the noncustodial parent lives in one State and the custodial parent and child(ren) live in another State.

APPENDIX C: Legislation

Legislative History of Major Medical Support Provisions

1974: Pub. L. 93-406 **The Employee Retirement Income Security Act of 1974 (ERISA).** Regulated most privately sponsored pension plans and health benefit plans. Covered such health benefit plans regardless of whether benefits are provided through the purchase of insurance or from the sponsor's or the plan's general assets. Imposed health plan benefit requirements related to information which must be provided to plan participants and beneficiaries; internal procedures for determining benefit claims; and standards of conduct of those responsible for plan management. Included a broad "preemption" provision, which provides that unless one of the statutory exceptions applies, the provisions of ERISA supersede any State laws that relate to any covered plan.

1975: Pub. L. 93-647 **The Social Services Amendments of 1974.** Created Title IV-D of the Social Security Act to establish the Child Support Enforcement Program, in which the Secretary of Health, Education, and Welfare (now Secretary of Health and Human Services) is charged with the responsibility for overseeing the operation of the new program, including the following major functions: establishing a parent locator service; establishing standards for State program organization, staffing, and operation; reviewing and approving State plans; providing technical assistance to States; maintaining records of program operations, expenditures, and collections; and submitting an annual report to Congress. Primary responsibility for direct program operations—including locating absent parents, establishing paternity, and securing support for individuals receiving AFDC—was assigned to States. Applicants and recipients for AFDC were required to assign their rights to child support to the State as a condition of eligibility.

1977: Pub. L. 95-142 **The Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977.** Established a medical support enforcement program under which States could require Medicaid applicants to assign to the State their rights to medical support. State Medicaid agencies allowed to enter into cooperative agreements with any appropriate agency of any State, including the IV-D agency, for assistance with the enforcement and collection of medical support obligations. Incentives were made available to agencies making child support collections for States and to States securing collections on behalf of other States.

1984: Pub. L. 98-378 **The Child Support Enforcement Amendments of 1984**. Mandated that all States enact statutes providing for such improved child support enforcement mechanisms as: (1) mandatory income withholding procedures; (2) expedited processes for establishing and enforcing support orders; (3) State income tax refund interceptions; (4) liens against real and personal property; (5) the formulation of guidelines for determining appropriate child support obligations and the distribution of guidelines to judges and other individuals with authority to establish obligation amounts; (6) establishment of medical support awards in addition to cash support awards; (7) allowing paternity actions any time prior to a child's 18th birthday; and (8) submission of reports of support delinquency information to consumer reporting agencies.

1988: Pub. L. 100-485 **The Family Support Act of 1988**. Judges and other officials required to use State guidelines for support awards unless they are rebutted by a written finding that applying the guidelines would be unjust or inappropriate in the case. Required States to: (1) meet Federal standards for the establishment of paternity beginning in FY 1992; (2) require all parties in a contested paternity case to take a genetic test upon request of any party; and (3) develop a Federally-approved, single, statewide automated data processing and retrieval system with the capacity to process IV-D cases statewide by October 1, 1995. (This deadline was later extended to October 1, 1997.) States were also encouraged to adopt a simple civil process for voluntarily acknowledging paternity and a civil procedure for establishing paternity in contested cases.

1988: Pub. L. 101-239 **The Omnibus Budget Reconciliation Act of 1989**. Made permanent the requirement that Medicaid benefits continue for four months after a family loses AFDC eligibility as a result of collection of child support payments.

1993: Pub. L. 103-66 **The Omnibus Budget Reconciliation Act of 1993 (OBRA '93)**. Amended Title XIX of the Social Security Act by adding §1908 to require States to have laws prohibiting employers and insurers from denying enrollment of a child under a parent's family health coverage plan due to various factors such as: the child being born out of wedlock, the child was not claimed as dependent on the parent's Federal income tax return, or the child does not live with the parent or in the insurer's service area. State Title XIX agencies were permitted to garnish wages, salary, or other employment income, and withhold State tax refunds from any person who is legally required by court or administrative order to offer coverage of health services costs to a child eligible for medical assistance under Title XIX and who has received payment from a third party but has not reimbursed either the other parent or guardian of the child or the provider of the services.

Also amended ERISA by adding §609 (29 U.S.C. §1169) which, among other things, requires covered group health plans to provide benefits in accordance with applicable requirements of "medical child support orders" that satisfy the statutory requirements contained in this section related to "qualified medical child support orders" (QMCSOs). For purposes of §609, a "medical child support order" was defined to mean a judgment, decree, or order issued by a court of competent jurisdiction which provides for child support with respect to a child of a health plan participant or for health coverage of a child of a participant, or which enforces a law relating to medical child support described in §1908 of the Social Security Act with regard to a group health plan.

1996 Pub. L. 104-193 **The Personal Responsibility and Work Opportunity Act of 1996.** Established the requirement that States implement further expedited administrative procedures for establishing paternity and for establishing, modifying, and enforcing support obligations and develop and expand additional databases of State IV-D agencies. Also expanded the authority of IV-D agencies to act without obtaining an order from a judicial or administrative tribunal and required IV-D agencies to expand their use of administrative enforcement remedies, including income withholding, seizure of funds, statutory liens, voiding of fraudulent property transfers, license suspension, repayments, work requirements, credit bureau reporting, and passport revocations. All IV-D orders were required to include a provision for health care coverage. (Previously, IV-D agencies were required to simply petition for the inclusion of medical support in new and modified support orders when health care coverage was available to the noncustodial parent through employment-related or other group family health coverage.) States were also required to provide for a simple administrative process for enrolling a child in a new health plan involving the use of a notice of coverage, which operates to enroll a child in a new employer's health plan.

Also amended §609(a) of ERISA to expand the definition of "medical child support orders" to permit certain administrative orders to be considered QMCSOs if applicable requirements in §609(a) are satisfied. (This expanded definition permitted administrative agencies to issue QMCSOs, whereas previously only courts were allowed to do so.)

1997 Pub. L. 105-33 **The Balanced Budget Act of 1997.** Created Title XXI of the Social Security Act to establish the State Children's Health Insurance Program (SCHIP), which provides funds to States to enable them to initiate or expand the provision of child health assistance to uninsured children of low-income families. Established a flexible administrative framework that enables States to operate their respective SCHIP programs as an extension to the Medicaid Program, as a separate entity, or as a combination of these two approaches.

1998 Pub. L. 105-200 **The Child Support Performance and Incentive Act of 1998.** Mandated that several actions be taken to improve medical support enforcement in the child support enforcement program, including: (1) the joint establishment of a Medical Support Working Group by the Secretaries of HHS and Labor to identify impediments to the effective enforcement of medical support by State IV-D agencies and submit to the Secretaries of HHS and Labor a report containing recommendations addressing identified impediments; (2) the joint development and promulgation of a National Medical Support Notice by the Departments of HHS and Labor, to be issued by State IV-D agencies as a means of enforcing health care coverage provisions contained in child support orders; (3) the joint development and issuance by the Departments of HHS and Labor of Federal interim and final regulations which include appropriate procedures for the transmission of the National Medical Support Notice to employers by State IV-D agencies; and (4) the joint submission by the Secretaries of HHS and Labor of a Report to Congress that addresses recommendations made by the Working Group and includes an assessment of the National Medical Support Notice. In addition, the HHS Secretary, in consultation with State IV-D Directors and representatives of children potentially eligible for medical support, was directed to develop a performance measure based on the effectiveness of States in establishing and enforcing medical support obligations and to make recommendations for the incorporation of the measure in a revenue neutral manner into the Child Support Incentive Payment System, no later than October 1, 1999.

APPENDIX D: Health Care Coverage for Child Support-Eligible Children

In this Report, 21 million children were considered to be potentially eligible for child support as of 1995. Child support-eligible children are children under age 19 whose parents are divorced, separated, or never-married (and not cohabiting). Children are considered eligible for support regardless of current child support award or custody status. About 17 percent of child support-eligible children live in a married two-parent household (with a custodial parent and step-parent). Age 18 was used as the upper age limit because most states limit mandatory parental obligations for support to children under age 18 or until completion of secondary school. Additionally, eligibility for employment-based dependent health care coverage and for public coverage often terminates around this age. It is recognized that some children older than 18 may continue to be eligible for child support (and for private or public health care coverage), depending on individual circumstances, such as adult disabled children or children attending college. In addition, some children under age 19 who do not live with either parent are also eligible for child support. However, national data does not allow us to identify these children.

The tables below provide information on the status of children's health care coverage. Data indicates that about 13 percent of child support-eligible children have at least two different kinds of coverage (such as multiple private, public and private, or private plus other insurance, such as CHAMPUS (health care for military dependents) during the course of a year. Coverage from any source may only be for part of the year. Children identified as being insured had some type of health care coverage during part or all of the year. Children identified as uninsured have no coverage during the entire year. Current data sources do not allow us to identify children who have coverage some part of the year and no coverage during other parts of the year. Therefore, these tables underestimate the number and percent of children who may not have coverage for some part of the year.

The first four tables (Tables 1-1 through 1-4) provide information based on the child support-eligible population as of 1995. Table 1-1 provides information on the number of children with and without health care coverage by family income expressed as a percent of the poverty. Health care coverage includes private, public, and other coverage such as CHAMPUS (health care for military dependents). Tables 1-2 and 1-3 are elaborations of Table 1-1. Information is presented for child support-eligible children who live with one parent and for children who live in a step-parent family. Table 1-4 provides information only for child support-eligible children with private coverage. In this table, income is expressed as a percent of the poverty and private coverage is broken down by provider source: from within the household (e.g., parent, step-parent), and from outside the household (most likely the noncustodial parent). For those children with private coverage, Medicaid and other coverage is also indicated.

TABLE 1-1
Child Support-eligible Children by Poverty and Health Coverage Status (1996 CPS-CSS)

[illegible]	Total	<100% poverty	100% to <200% poverty	200% to <300% poverty	>300% poverty
Private	10.4m (49%)	1.6m (19%)	2.7m (51%)	2.6m (75%)	3.6m (84%)
Public	8.6m (40%)	5.9m (72%)	1.8m (35%)	.5m (14%)	.4m (09%)
Other	.8 m (04%)	.3m (04%)	.24m (06%)	.14m (05%)	.14m (04%)
Insured*	18.2m (86%)	7.1m (87%)	4.3m (81%)	2.9m (87%)	3.9m (91%)
Uninsured**	2.9 m (14%)	1.1m (13%)	1.0m (19%)	.45m (13%)	.4m (09%)
Total***	21.1m	8.2m	5.3m	3.4m	4.2m

* Insured at any time during the year. Total of children with private, public and other health care coverage greater than total insured because 13% of children have simultaneous or sequential coverage during the year.

** Indicates no health care coverage at anytime during the year

*** Total child support-eligible children

TABLE 1-2
Child Support-Eligible Children in Single Parent Households with Private Health Care Coverage by Poverty and Coverage Source (1996 CPS-CSS)

[illegible]	Total	<100% poverty	100% to <200% poverty	200% to <300% poverty	>300% poverty
Private within household	5.8m (34%)	.74m (10%)	1.6m (36%)	1.5m (58%)	1.9m (66%)
Private outside household	2.6m (15%)	.79m (10%)	.77m (17%)	.50m (19%)	.54m (19%)
Public	8.0m (46%)	5.6m (74%)	1.6m (37%)	0.41m (16%)	.35m (12%)
Other	0.57m (03%)	.25m (03%)	0.14m (03%)	0.08m (03%)	.09m (03%)
Insured *	15.1m (86%)	6.6m (87%)	3.7m (81%)	2.3m (86%)	2.5m (89%)
Uninsured**	2.5m (14%)	.96m (13%)	0.83m (19%)	.37m (14%)	.32m (11%)
Total children***	17.6m	7.6m	4.5m	2.6m	2.9m

* Insured at any time during the year. Total of children with private, public and other health care coverage greater than total insured because children have simultaneous or sequential coverage during the year

** Indicates no health care coverage at anytime during the year

*** Total child support-eligible children in single parent household

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TABLE 1-3 Child Support-Eligible Children In Two Parent Households with Private Health Care Coverage by Poverty and Coverage Source (1996 CPS-CSS)

[illegible]	Total	<100% poverty	100% to <200% poverty	200% to <300% poverty	>300% poverty
Private within household	2.4m (67%)	.15m (24%)	.4m (50%)	.56m (76%)	1.25m (90%)
Private outside household	.48m (14%)	.04m (07%)	.08m (10%)	.11m (15%)	.25m (18%)
Public	.6m (17%)	.3m (51%)	.18m (23%)	.07m (10%)	.05m (03%)
Other	.24m (07%)	.04m (07%)	.10m (13%)	.05m (07%)	.05m (03%)
Insured*	3.1m (87%)	.47m (80%)	.61m (76%)	.66m (89%)	1.3m (96%)
Uninsured**	.44m (13%)	.12m (20%)	.19m (24%)	.08m (11%)	.05m (04%)
Total children***	3.5m	.59m	.8m	.74m	1.4m

* Insured at any time during the year. Total of children with private, public and other health care coverage greater than total insured because children have simultaneous or sequential coverage during the year

** Indicates no health care coverage at anytime during the year

*** Total child support-eligible children two parent families

TABLE 1-4
Child Support-Eligible Children with Private Health Care Coverage by Poverty and Coverage Source (1996 CPS-CSS)

[illegible]	Total	<100% poverty	100% to <200% poverty	200% to <300% poverty	>300% poverty
Private within household	8.1m	0.88m	2.0m	2.1m	3.2m
Private outside household	3.1m	0.83m	0.85	0.6m	0.8m
Public	0.5m	0.49m	0.37m	0.16m	0.13m
Other	0.15m	0.08m	0.10m	0.07m	0.09m
Private* Coverage	10.4m	1.6m	2.7m	2.6m	3.6m

* Private coverage at any time during the year. Sum of private, public and other health care coverage greater than total with private coverage because children have simultaneous or sequential coverage during the year

Tables 2-1 and 2-2 (below) show health care coverage trends for 1995-1998 from the March Current Population Income Supplement in 1996-1999. This data is not limited to the child support-eligible population but includes all children in single- and two-parent households. This data is provided to show likely trends in health care coverage for the child support-eligible population from 1995-1998. For children in single parent households, the number and proportion of children with private health care coverage has increased, but the number of children and proportion with public coverage has decreased at a faster rate, thereby increasing the total number

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of children with no health care coverage of any kind. The changes for child support-eligible children are more likely to resemble the changes in single parent households, because the majority of child support-eligible children (83 percent) live in single-parent households.

TABLE 2-1
Children in Single Parent Households by Health Coverage Status and Year (1996-1999 CPS)

	1996	1997	1998	1999	Change 96-99 # (%)
Private	9.1m (43%)	9.3m (44%)	9.5m (45%)	9.9m (47%)	+9 % (+9%)
Public	9.4m (45%)	8.9m (42%)	8.3m (39%)	8.1m (38%)	-14% (-16%)
Other	0.71m (03..3%)	0.75m (03.6%)	0.72m (03.4%)	0.79m (03.7%)	+11% (+12%)
Insured*	17.7m (84%)	17.2m (82%)	17.2m (81%)	17.1m (80%)	-3.4% (-4.8%)
Uninsured**	3.5m (16%)	3.8m (18%)	4.0m (19%)	4.2m (20%)	+2.2% (+2.5%)
Total***	21.1m	21.0m	21.2m	21.3m	+1%

* Insured at any time during the year. Total of children with private, public and other health care coverage greater than total insured because children have simultaneous or sequential coverage during the year

** Indicates no health care coverage at anytime during the year

*** Total children in single-parent households

TABLE 2-2
Children in Two Parent Households by Health Coverage Status and Year (1996-1999 CPS)

	1996	1997	1998	1999	Change [illegible]
Private	39.5m (78%)	39.7m (78%)	40.2m (79%)	40.7m (79%)	+3% (+1.6%)
Public	6.0m (12%)	5.5m (11%)	5.4m (11%)	5.2m (10%)	-13% (-17%)
Other	2.6m (05.1%)	2.4m (04.7%)	2.3m (04.5%)	2.3m (04.5%)	-12% (-12%)
Insured*	44.6m (88%)	44.6m (88%)	45.0m (88%)	45.4m (88%)	+2% (0%)
Uninsured**	5.9m (12%)	6.2m (12%)	6.1m (12%)	6.1m (12%)	+3% (0%)
Total***	50.6m	50.8m	51.1m	51.4m	1.5%

* Insured at any time during the year. Total of children with private, public and other health care coverage greater than total insured because children have simultaneous or sequential coverage during the year.

** Indicates no health care coverage at anytime during the year

*** Total children in two parent households

Source: Data for tables 1-1 through 1-4 is from the 1996 March-April public use match file of the Current Population Survey(CPS)—Income(March) and Child Support (April) Supplements. The CPS is conducted by the Bureau of the Census. The 1996 data file represents income and child support status as of calendar year 1995. This was the latest data available that could identify the

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health care coverage status of child support-eligible children. Data for tables 2-1 and 2-2 are from the 1996, 1997, 1998, and 1999 CPS-March Income Supplement. All data tabulations were produced by HHS/Office of Planning and Evaluation specifically for this Report.

APPENDIX E: National Medical Support Notice

Technical Revision Recommendations

The proposed National Medical Support Notice is comprised of two parts: Part A, Employer Withholding Notice, and Part B, Medical Support Notice to the Plan Administrator. Each part includes the actual notice containing information to be provided by the State IV-D agency, including the names and mailing addresses of the employee/obligor, the child and the employer, and the type of coverage to be provided, such as basic, dental, vision, mental health, and prescription. They also contain information related to the underlying child support order.

Part A includes an Employer Response form. If the employer does not offer group health coverage or if the employee is not employed by the employer, the employer checks the appropriate box and returns it to the State agency. Otherwise, the employer forwards Part B to the appropriate plan administrator. If, after receiving enrollment information from the plan administrator, the employer determines that State or Federal withholding limitations prevent withholding the required employee contribution to obtain coverage, the employer checks the appropriate box and returns the Response to the State agency.

Part A also includes Instructions to Employer, which informs the employer of the following: its responsibilities with respect to the Notice, including forwarding Part B to the administrator of each group health plan in which the child may be eligible to enroll; the limitations on and priority of withholding; the duration of the withholding obligation; possible sanctions the employer may be subject to; the employer's obligation to notify the State agency if the employee's employment terminates; the employee's liability for making any necessary employee contributions to the plan; and a means to contact the State agency with any questions.

Part B includes a Plan Administrator Response form that the administrator of a group health plan uses to notify the State agency of the following: any defects in the Notice (by checking the appropriate box); when it was determined to be a QMCSO; whether the child has been enrolled in the plan or, if not, what options are available (indicated by checking the appropriate box); and the effective date of coverage and the options selected.

The Instructions to the Plan Administrator informs the Plan Administrator of his/her responsibilities with respect to the Notice. These responsibilities include the need to: inform the parties when coverage is effective and provide a description of the coverage; provide the custodial parent with forms, documents, and information necessary to effectuate coverage; and notify the participant that his/her coverage may change based on an election made for the child. The Instructions also inform the administrator that the child may not be denied coverage on the ground that the child was born out of wedlock, is not claimed as a dependent on the participant's Federal income tax return, or does not reside with the participant, and that enrollments must be made without regard to open season restrictions. Finally, the Instructions inform the administrator that the child is to be treated as a dependent under the terms of the plan, that the child may be entitled to COBRA continuation coverage under certain circumstances, and the conditions under which the child may be dis-enrolled from the plan.

Technical Notice Comments

Parts A and B (IV-D agency portion)

1. That "court name" in the common case identification data section of both Parts A and B be changed to "Court or Administrative Authority" to recognize cases in which the order has been issued by an administrative authority rather than by a court.

2. That the phrase "alternate recipient(s)/child(ren)" be replaced by "child(ren)" throughout the Notice. Similarly, "employee/obligor" should be replaced by "employee."

3. The types of coverage at the bottom of both Parts A and B should be replaced with the following language:

   The order requires the child(ren) be enrolled in [ ] any health coverages available under your plan or [ ] only the following coverage(s): ___ Medical; ____ Dental; ____ Vision; ___ Prescription drug; ____ Mental health; ____ Other (specify):___________________.

Employer Response (Part A)

4. The parenthetical just below the title should be revised to read: "To be completed within 20 business days after the date of the Notice or sooner if reasonable" and moved so that it only applies to whether family health coverage is available to the employee through the employer (not to whether withholding limitations prevent the withholding of required employee contributions). This will make the time limit clearer.

5. The Employer Response would be easier to read and the responses would be more useful to the agency if response 1 were split into two responses:

   1. Employer does not provide any family health coverage.
   2. The employee is among a class of employees that are not eligible for family health coverage (for example, part-time or non-union employees).

[The current response 2 would become response 3, and current response 3 would become response 4.]

6. In current response 2 (renumbered 3), a line should be added for "Date of termination:"

7. Space for the employer's EIN (employer identification number) should be added at the bottom of the Employer Response, to be completed if the EIN is not shown on the portion of the Notice completed by the IV-D agency.

Instructions to Employers (Part A)

8. That the word "also" be deleted from the first sentence under Instructions To Employer where reference is made to "children identified above."

9. That the clause "As the employer of the employee, you are required to:" in the first sentence under Employer Responsibilities, Part A, be deleted. (These responsibilities are included under the general heading of Instructions To Employers so it is evident that they apply to the employer who previously has been identified by name.

10. That the first sentence in Part A under Limitations on Withholding be revised to clarify that the maximum CCPA limit applies to the combined amount withheld for both cash and medical support. The following language is proposed: "The total amount withheld for both cash and medical support cannot exceed ___% of the Employee's aggregate disposable weekly earnings."

11. That Item 3 under Limitations on Withholding in the instructions to Part A be revised to allow each Issuing Agency to indicate the amount allowed by the child support order. The following language is proposed to replace the current Item 3: "The amounts allowed for medical support by the child support order, as indicated here:" Similarly, under Priority of Withholding, the Issuing Agency should be allowed to insert a description of priorities under state law, if any.

    (These amounts and methods of calculation differ from State to State and Employers will not know them unless the employers are informed by the Issuing Agency.)

12. That the paragraph in the section under Notice of Termination of Employment, Part A, be revised to eliminate unnecessary words. The following language is proposed: " In any case in which the employee's employment terminates, the Employer must promptly notify the Issuing Agency listed above of such termination. This requirement may be satisfied by sending the Issuing Agency a copy of any notice the Employer is required to provide under…"

Plan Administrator Response (Part B)

13. The parenthetical just below the title should be revised to read: "(To be completed and returned to the Issuing Agency within 40 business days after the date of the Notice or sooner if reasonable)." This will make the time limit for the response more prominent.

14. Part B deals first with orders that are not qualified and then orders that are qualified, but the instructions are in the opposite order. The form and the instructions should be in the same order. It would probably be best if the current response 1 (the order is not qualified), be made the last on the Response.

15. In the second sentence of response 2 on Part B, the phrase "If dependent only coverage is not available" is confusing and should be eliminated. Few plans have such coverage. Even in a plan that had such coverage, it is not clear what should happen. Dependent only coverage may not always be the appropriate choice. For example, if the employee already has family coverage that covers the employee the plan should not disturb the existing coverage (particularly since that could deprive other children of coverage).

16. If the Notice is determined to be a qualified order and the employee is enrolled in a plan (or option within the plan) that has family coverage available, the Plan Administrator Response (Part B) should so indicate and the plan administrator should enroll the child in that option. A new b. and c. should be inserted under 2, as follows:

    b. The participant is enrolled in an option that is providing dependant coverage and the child(ren) will be enrolled in the same option;
    c. The participant is enrolled in an option that permits dependent coverage that has not been elected; dependent coverage will be provided.

    The instructions would then indicate that the Plan Administrator should inform the Employer to withhold any additional employee contribution.

17. A new item 2 should be added for the plan administrator to indicate whether the child is outside of the service area, or if the plan administrator cannot make that determination (for instance, if a State official has been substituted for the address of the child).

18. Current item 2b should be renumbered to 3, and the lines provided for Plan Administrator to indicate the various options should be revised as follows to permit the Plan Administrators to indicate the respective employee premium amount for each option and whether the plan has a limited geographic service area:

    Each child may be included as a dependent under one of the following options that provide family coverage:

Option	Additional Cost to Cover Child	Plan Service Area Limited	Default
☐ (1) ______________________	__________	__________	[ ]
☐ (2) ______________________	__________	__________	
☐ (3) ______________________	__________	__________	

    The plan administrator would be instructed to list the plan's default option, if any, first and to enroll the child in that option if there is no response from the IV-D agency within [20] business days.

19. In the first sentence of the current item 3 the word "all" should be replaced with "sufficient."

20. "PIN or Contract Number" should be replaced with "Plan, policy or contract number".

Instructions to the Plan Administrator

21. Starting the instructions to the plan administrator with the Paperwork notice is confusing and makes it difficult to find the start of the real instructions. The Paperwork notice should be eliminated, moved to the end or separated in some way so that the reader can find the beginning of the instructions.

22. That a sentence be added in Instructions to the Plan Administrator to clearly indicate that: "If the plan requires that the Employee be enrolled in order for the child(ren) to be enrolled, you must enroll both the employee and the child(ren)." This sentence might be added at the end of the section on Unlawful Refusal to Enroll.

23. The instructions should make it clear that the plan administrator is allowed to attach the plan's enrollment information or summary plan description to provide the information required in new responses 3 and 4, since it won't necessarily fit in the space provided and the enrollment materials are likely to contain additional information.

24. If the Notice covers more than one child but fails to provide the address of one of the children, the instructions should make clear that the Notice should be treated as a qualified order with respect to the children for whom the address has been provided. Similarly, if the employee's address is not provided but the plan has a record of the address in its files, the instructions should make it clear that the absence of the address does not disqualify the order. This is similar to guidance that DOL has provided with respect to QDROs.

25. Instruction (A)(1) should be divided into two separate instructions as follows:

    (1) Complete Part B - Plan Administrator Response and send it to the Issuing Agency;
    (2) Notify the employee, each child and the custodial parent that coverage of the child(ren) is or will become available (notification of the custodial parent will be deemed notification of the child(ren) who reside at the same address);

    [(2), (3), (4), (5) and (6) should be renumbered.]

26. Current instruction (A)(4) (renumbered (6)) should be reworded as follows:

    (6) if the option in which the participant is enrolled does not provide coverage for children or the child(ren) are outside of the option's service area, notify the participant that this Notice may require that the option that he or she has elected be changed in order to enroll the child(ren)

27. An example should be added at the end of current instruction (A)(5)(b) as follows: "(for example, selection of the coverage option if more than one option is available)."

28. An instruction should be added informing the plan administrator that if the IV-D agency does not respond within 20 business days after the administrator has returned the Plan Administrator Response informing the IV-D agency that a choice among more than one option is required, and the plan has a default option, the administrator is to enroll the child(ren), and the participant if necessary, in the plan's default option.

29. The plan administrator should send the description of the coverage only to the custodial parent (or the Substitute Official if the custodial parent's address is not given), not to the Issuing Agency.

30. If some options (such as HMOs) have a limited geographic service area and the child's address or zip code is not provided, the instructions should advise the plan administrator to contact the Issuing Agency for information necessary to determine which options are available in the child's area.

31. Add instructions dealing with waiting period and withholding limits consistent with process recommendations.

32. Explain "Employee Cost."

APPENDIX E

Notice

NATIONAL MEDICAL SUPPORT NOTICE OMB NOS.
PART A
EMPLOYER WITHHOLDING NOTICE

This Notice is issued under Section 466(a)(19) of the Social Security Act and Section 609(a)(5)(C) of the Employee Retirement Income Security Act of 1974 (ERISA).

Issuing Agency: ____________________
Issuing Agency Address: ____________________
____
Date of Notice: ____________________
Case Number: ____________________
Telephone Number: ____________________

Court or Administrative Authority: ____________________
Date of Support Order: ____________________
Support Order Number: ____________________

____________________)
Employer/Withholder's Federal EIN Number

____________________)
Employer/Withholder's Name

____________________)
Employer/Withholder's Address

____________________)
Custodial Parent's Name (Last, First, MI)

____________________)
Custodial Parent's Mailing Address

____________________)
Child(ren)'s Mailing Address (if different from Custodial Parent's)

____________________)
____________________)
____________________)
Name, Mailing Address, and Telephone Number of a Representative of the Child(ren)

RE* ____________________
Employee's Name (Last, First, MI)

____
Employee's Social Security Number

____
Employee's Mailing Address

____
Substituted Official/Agency Name and Address

Child(ren)'s Name(s)	DOB	SSN	Child(ren)'s Name(s)	DOB	SSN
____________	______	______	____________	______	______
____________	______	______	____________	______	______
____________	______	______	____________	______	______

The order requires the child(ren) to be enrolled in [ ] any health coverages available under your plan; or [] only the following coverage(s): __medical; __dental; __vision; __prescription drug; __mental health; __other (specify):____________________

EMPLOYER RESPONSE

If either 1, 2, or 3 below applies, check the appropriate box and return this Part A to the Issuing Agency within 20 business days after the date of the Notice, or sooner if reasonable. NO OTHER ACTION IS NECESSARY. If neither 1, 2, nor 3 applies, forward Part B to the appropriate plan administrator(s) within 20 business days after the date of the Notice, or sooner if reasonable. Check number 4 and return this Part A to the Issuing Agency if the Plan Administrator informs you that the child(ren) is/are enrolled in an option under the plan for which the employee contribution exceeds the amount that may be withheld from the employee's income due to State or Federal withholding limitations and/or prioritization.

☐ 1. Employer does not maintain or contribute to plans providing dependent or family health care coverage.

☐ 2. The employee is among a class of employees (for example, part-time or non-union) that are not eligible for family health coverage under any group health plan maintained by the employer or to which the employer contributes.

☐ 3. Health care coverage is not available because the employee is no longer employed by the employer:

Date of termination: ____________________

Last known address: ____

Last known telephone number: ______________________________

New employer (if known): ____

New employer address: ____

New employer telephone number: ____________________________

☐ 4. State or Federal withholding limitations and/or prioritization prevent the withholding from the employee's income of the amount required to obtain coverage under the terms of the plan.

Employer Representative:

Name: ______________________________ Telephone Number: ______________

Title: ______________________________ Date: ________________

EIN (if not provided by Issuing Agency on Employer Withholding Notice): ___________

APPENDIX E

INSTRUCTIONS TO EMPLOYER

This document serves as notice that the employee identified on this Notice is obligated by a court or administrative child support order to provide health care coverage for the child(ren) identified on this Notice. This Medical Support Notice replaces any Medical Support Notice that the Issuing Agency has previously served on you with respect to the employee and the children listed on this Notice.

The document consists of **Part A - Employer Withholding Notice** for the employer to withhold any employee contributions required by the group health plan(s) in which the children is/are enrolled; and **Part B - Medical Support Notice to the Plan Administrator**, which must be forwarded to the administrator of each group health plan identified by the employer to enroll the eligible child(ren).

EMPLOYER RESPONSIBILITIES

1. If the individual named above is not your employee, or if family health care coverage is not available, please complete item 1, 2, or 3 of the Employer Response as appropriate, and return it to the Issuing Agency. NO FURTHER ACTION IS NECESSARY.

2. If family health care coverage is available for which the child(ren) identified above may be eligible, you are required to:

    a. Transfer, not later than 20 business days after the date of this Notice, a copy of **Part B - Medical Support Notice to the Plan Administrator** to the administrator of each appropriate group health plan for which the child(ren) may be eligible, and

    b. Upon notification from the plan administrator(s) that the child(ren) is/are enrolled, either

        1) withhold from the employee's income any employee contributions required under each group health plan, in accordance with the applicable law of the employee's principal place of employment and transfer employee contributions to the appropriate plan(s), or

        2) complete item 4 of the Employer Response to notify the Issuing Agency and the parties that enrollment cannot be completed because of prioritization or limitations on withholding.

    c. If the plan administrator notifies you that the employee is subject to a waiting period that expires more than 90 days from the date of its receipt of this Notice, or whose duration is determined by a measure other than the passage of time (for example, the completion of a certain number of hours worked), notify the plan administrator when the employee is eligible to enroll in the plan and that this Notice requires the enrollment of the child(ren) named in the Notice in the plan.

LIMITATIONS ON WITHHOLDING

The total amount withheld for both cash and medical support cannot exceed ___% of the employee's aggregate disposable weekly earnings. The employer may not withhold more than the lesser of:

1. The amounts allowed by the Federal Consumer Credit Protection Act (15 U.S.C., section 1673(b));

2. The amounts allowed by the State of the employee's principal place of employment; or

3. The amounts allowed for medical support by the child support order, as indicated here:________________________________.

In applying these limits, medical child support is the amount of additional employee premium which will be required to add family or dependent coverage. The premium required for individual coverage is subtracted from the cost of family coverage for this purpose. For example, if the employee premium is $50 for self-only coverage and $150 for family coverage, the amount of medical child support would be $100 ($150 minus $50).

The Federal limit applies to the aggregate disposable weekly earnings (ADWE). ADWE is the net income left after making mandatory deductions such as State, Federal, local taxes; Social Security taxes; and Medicare taxes.

PRIORITY OF WITHHOLDING

If withholding is required for employee contributions to one or more plans under this notice and for a support obligation under a separate notice and available funds are insufficient for withholding for both cash and medical support contributions, the employer must withhold amounts for purposes of cash support and medical support contributions in accordance with the law, if any, of the State of the employee's principal place of employment requiring prioritization between cash and medical support, as described here:

____

____.

DURATION OF WITHHOLDING

The child(ren) shall be treated as dependents under the terms of the plan. Coverage of a child as a dependent will end when similarly situated dependents are no longer eligible for coverage under the terms of the plan. However, the continuation coverage provisions of ERISA may entitle the child to continuation coverage under the plan. The employer must continue to withhold employee contributions and may not disenroll (or eliminate coverage for) the child(ren) unless:

1. The employer is provided satisfactory written evidence that:
    a. The court or administrative child support order referred to above is no longer in effect; or
    b. The child(ren) is or will be enrolled in comparable coverage which will take effect no later than the effective date of disenrollment from the plan; or
2. The employer eliminates family health coverage for all of its employees.

POSSIBLE SANCTIONS

An employer may be subject to sanctions or penalties imposed under State law and/or ERISA for discharging an employee from employment, refusing to employ, or taking disciplinary action against any employee because of medical child support withholding, or for failing to withhold income, or transmit such withheld amounts to the applicable plan(s), as the Notice directs.

NOTICE OF TERMINATION OF EMPLOYMENT

In any case in which the employee's employment terminates, the employer must promptly notify the Issuing Agency listed above of such termination. This requirement may be satisfied by sending the Issuing Agency a copy of any notice the employer is required to provide under the continuation coverage provisions of ERISA or the Health Insurance Portability and Accountability Act.

EMPLOYEE LIABILITY FOR CONTRIBUTION TO PLAN

The employee is liable for any employee contributions that are required under the plan(s) for enrollment of the child(ren) and is subject to appropriate enforcement. The employee may contest enforcement based on a mistake of fact (such as the identity of the obligor). Should an employee contest, the employer must proceed to comply with the employer responsibilities in this Notice until notified by the Issuing Agency to discontinue withholding. To contest enforcement, the employee should contact the Issuing Agency at the address and telephone number listed on the Notice.

CONTACT FOR QUESTIONS

If you have any questions regarding this Notice, you may contact the Issuing Agency at the address and telephone number listed above.

NATIONAL MEDICAL SUPPORT NOTICE OMB NOS.
PART B
MEDICAL SUPPORT NOTICE TO PLAN ADMINISTRATOR

This Notice is issued under section 466(a)(19) of the Social Security Act and section 609(a)(5)(C) of the Employee Retirement Income Security Act of 1974 (ERISA). **Receipt of this Notice from the Issuing Agency constitutes receipt of a Medical Child Support Order under ERISA section 609(a)(5)(A) and (B).** The rights of the parties and the duties of the plan administrator under this NOTICE are in addition to the existing rights and duties established under such section.

Issuing Agency: ______________________
Issuing Agency Address: ______________________
____
Date of Notice: ______________________
Case Number: ______________________
Telephone Number: ______________________

Court or Administrative Authority: ______________________
Date of Support Order: ______________________
Support Order Number: ______________________

______________________________)
Employer/Withholder's Federal EIN Number

______________________________)
Employer/Withholder's Name

______________________________)
Employer/Withholder's Address

______________________________)
Custodial Parent's Name (Last, First, MI)

______________________________)
Custodial Parent's Address

______________________________)
Child(ren)'s Mailing Address (if Different from Custodial Parent's)

______________________________)
______________________________)
______________________________)
Name(s), Mailing Address, and Telephone Number of a Representative of the Child(ren)

RE* ______________________________
Employee's Name (Last, First, MI)

____
Employee's Social Security Number

____
Employee's Address

____
Substituted Official/Agency Name and Address

Child(ren)'s Name(s)	DOB	SSN	Child(ren)'s Name(s)	DOB	SSN

The order requires the child(ren) to be enrolled in [] any health coverages available under your plan; or [] only the following coverage(s): __medical; __dental; __vision; __prescription drug; __mental health; __other (specify):______________________

PLAN ADMINISTRATOR RESPONSE

(To be completed and returned to the Issuing Agency within 40 business days after the date of the Notice, or sooner if reasonable)

This Notice was received by the plan administrator on ________.

☐ 1. This Notice was determined to be a "qualified medical child support order," on _______. The employee and child(ren) are to be enrolled in the following family coverage. Complete question 4.

☐ a. There is only one type of coverage provided under the plan. The child(ren) is/are included as dependents of the participant under the plan.

☐ b. The participant is enrolled in an option that is providing dependent coverage and the child(ren) will be enrolled in the same option.

☐ c. The participant is enrolled in an option that permits dependent coverage that has not been elected; dependent coverage will be provided.

2. ☐ a. The child is outside of the plan/option's service area.

☐ b. The plan administrator cannot determine if the child is in the plan/option's service area.

☐ 3. This Notice is qualified, but there is more than one option available under the plan and the participant is not enrolled, or is enrolled in an option that is not accessible to the child(ren). The Issuing Agency must select from the available options and return this Part B to the Plan Administrator named below for processing. Each child is to be included as a dependent under one of the following options that provide family coverage. List the plan's default option, if any, first. If you receive no response from the Issuing Agency within 20 business days after the return of this Response, enroll the child(ren), and the participant if necessary, in the default option:

Option	Additional Employee Contribution to cover the child(ren)	Limited Service Area?	Default
☐ (1) ____________________	___________	___________	[ ]
☐ (2) ____________________	___________	___________	
☐ (3) ____________________	___________	___________	

☐ 4a. The plan administrator received sufficient information necessary for enrollment on ______(date). Coverage is effective as of __________. Any necessary withholding should commence if permitted under State and Federal withholding and/or prioritization limitations. The child(ren) has/have been enrolled in the following option(s):

Name and address of plan or insurance carrier(s):	Plan, Policy or Contract number:	Address to submit claims:
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

4b. The plan administrator ☐ has ☐ has not confirmed that the necessary withholding is available under applicable State and Federal withholding limitations.

☐ 5. This Notice is qualified, but the participant is subject to a waiting period that expires more than 90 days from the date of receipt of this Notice, or the duration of which is determined by some measure other than the passage of time (for example, the completion of a certain number of hours worked). Upon the satisfaction of the waiting period, the employer will notify the plan administrator that the participant is eligible to enroll in the plan and that this Notice requires the enrollment of the child(ren) named in the Notice, and the participant if necessary to enroll the child(ren).

☐ 6. This Notice does not constitute a "qualified medical child support order" because:
  - ☐ The name of the ☐ child(ren) or ☐ participant is missing.
  - ☐ The mailing address of the ☐ child(ren) or ☐ participant is missing.
  - ☐ The following child(ren) is/are at or above the age at which dependents are no longer eligible for coverage under the plan ____________________ (insert name(s) of child(ren)).

Plan Administrator or Representative:
Name: ______________________________ Telephone Number: _____________

Title: ______________________________ Date: ________________

Address: ____________________________________

INSTRUCTIONS TO PLAN ADMINISTRATOR

This Notice has been forwarded from the employer identified above to you as the plan administrator of a group health plan maintained by the employer (or a group health plan to which the employer contributes) and in which the noncustodial parent/participant identified above is enrolled or is eligible for enrollment.

This Notice serves to inform you that the noncustodial parent/participant is obligated by an order issued by the court or agency identified above to provide health care coverage for the child(ren) if available under the group health plan(s) as described on **Part B**.

(A) If the participant and child(ren) and their mailing addresses (or that of a Substituted Official or Agency) are identified above, and if coverage for the child(ren) is or will become available, this Notice constitutes a "qualified medical child support order" under ERISA, and you must, within 40 business days of the date of this Notice, or sooner if reasonable:

(1) Complete **Part B - Plan Administrator Response** and send it to the Issuing Agency;

(2) notify the noncustodial parent/participant named above, each named child, and the custodial parent that coverage of the child(ren) is or will become available (notification of the custodial parent will be deemed notification of the child(ren) if they reside at the same address);

(3) furnish the custodial parent a description of the coverage available and the effective date of the coverage, either on the Plan Administrator Response or attached thereto (such as a summary plan description);

(4) provide to the custodial parent any forms, documents, or information necessary to effectuate such coverage (including the applicability of creditable coverage under HIPAA);

(5)(a) if no other information or action is required, include the child(ren) in the available coverage, or,

(b) notify the custodial parent and the Issuing Agency of any additional steps to be taken (for example, selection of the coverage option if more than one option is available);

(6) if the option in which the participant is enrolled does not provide coverage for children or the child(ren) are outside of the option's service area, notify the participant that this Notice may require that the option that he or she has elected be changed in order to enroll the child(ren);

(7) if some or all of the options under the plan are limited to specified geographic service areas (e.g., specific zip codes):

(a) if a Substitute Official's name and address has been substituted for the address of the custodial parent and child(ren), indicate that geographic restrictions apply and provide information that would allow the Issuing Agency to determine whether there is coverage that is accessible to the child(ren); or

(b) if the only available plan coverage is geographically limited and the child(ren) is/are outside the plan's service area, enroll the child unless the Issuing Agency notifies you not to enroll;

(8) if the participant is subject to a waiting period that expires more than 90 days from the date of receipt of this Notice, or whose duration is determined by a measure other than the passage of time (for example, the completion of a certain number of hours worked), check the appropriate box on the Plan Administrator Response and return to the Issuing Agency and the employer, and notify the participant and the custodial parent; and

(9) upon completion of the enrollment information, transfer the applicable information on **Part B** to the employer for a determination that the necessary employee contributions are available. Inform the employer that the enrollment is pursuant to a National Medical Support Notice, and what additional employee contribution, if any, is required to cover the child(ren) named on the Notice.

(B) If you checked box 3 on the **Plan Administrator Response** and the plan has a default option, you are to enroll the child(ren) in the default option within a reasonable period of time if you have not received a response from the Issuing Agency within 20 business days of the date you returned the Response. If the plan does not have a default option, you are not required to enroll the child(ren) until you receive a response from the Issuing Agency.

(C) If within 40 business days of the date of this Notice, or sooner if reasonable, you determine that this Notice does not constitute a "qualified medical child support order," you must complete **Part B - Plan Administrator Response** and send it to the Issuing Agency, and inform the noncustodial parent/participant, custodial parent, and child(ren) of the specific reasons for your determination. If the mailing addresses for one or more of the children are missing, but are present for others, this Notice constitutes a "qualified medical child support order" with respect to those children for whom the address is present (and to any others for whom a mailing address is known). Similarly, if the participant's mailing address is not present, but it is present in the plan's files, you may not find this Notice not to be a "qualified medical child support order" on that basis.

(D) Any required notification of the noncustodial parent, child(ren) and/or participant that is required may be satisfied by sending the party a copy of the **Plan Administrator Response**, if appropriate.

APPENDIX E

UNLAWFUL REFUSAL TO ENROLL

Enrollment of a child may not be denied on the ground that: (1) the child was born out of wedlock; (2) the child is not claimed as a dependent on the participant's Federal income tax return; or (3) the child does not reside with the participant or in the plan's service area. All enrollments are to be made without regard to open season restrictions. If the plan requires that the participant be enrolled in order for the child(ren) to be enrolled, you must enroll both the participant and the child(ren).

PERIOD OF COVERAGE

The child(ren) shall be treated as dependents under the terms of the plan. Coverage of a child as a dependent will end when similarly situated dependents are no longer eligible for coverage under the terms of the plan. However, the continuation coverage provisions of ERISA may entitle the child to continuation coverage under the plan. Once a child is enrolled in the plan as directed above, the child may not be disenrolled unless:

(1) The plan administrator is provided satisfactory written evidence that either:
  (a) the court or administrative child support order referred to above is no longer in effect, or
  (b) the child is or will be enrolled in comparable coverage which will take effect no later than the effective date of disenrollment from the plan;

(2) The employer eliminates family health coverage for all of its employees; or

(3) Any available continuation coverage is not elected, or the period of such coverage expires.

CONTACT FOR QUESTIONS

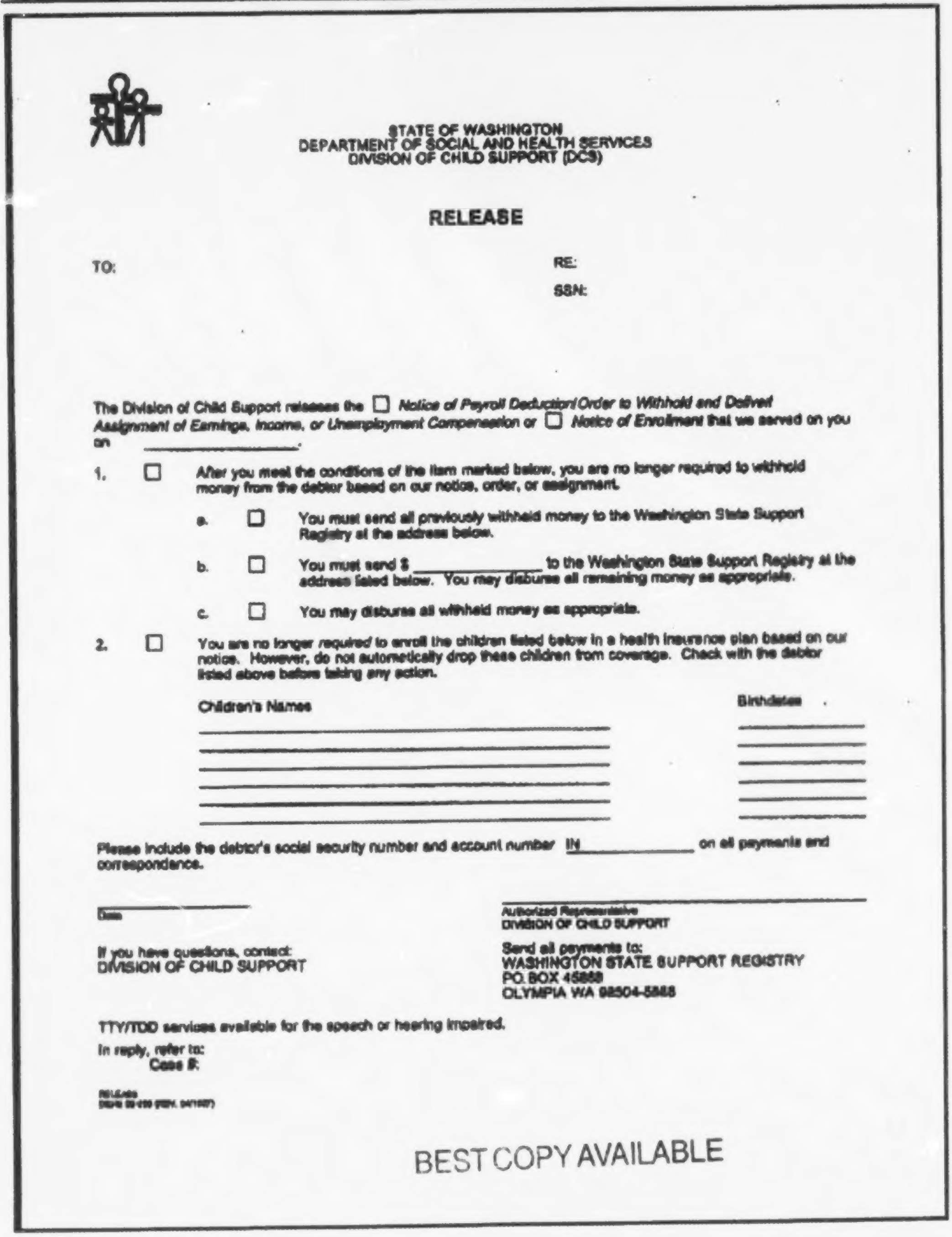
If you have any questions regarding this Notice, you may contact the Issuing Agency at the address and telephone number listed above.

Paperwork Reduction Act Notice

The Issuing Agency asks for the information on this form to carry out the law as specified in the Employee Retirement Income Security Act. You are required to give the Issuing Agency the information. You are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Issuing Agency needs the information to determine whether health care coverage is provided in accordance with the underlying child support order. The Average time needed to complete and file the form is estimated below. These times will vary depending on the individual circumstances.

	Learning about the law or the form	Preparing the form
First Notice	1 hr.	1 hr., 45 min.
Subsequent Notices	------	35 min.

APPENDIX F: Washington State Model Notice of Release Form



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
DIVISION OF CHILD SUPPORT (DCS)

RELEASE

TO:

RE:
SSN:

The Division of Child Support releases the ☐ *Notice of Payroll Deduction/Order to Withhold and Deliver Assignment of Earnings, Income, or Unemployment Compensation* or ☐ *Notice of Enrollment* that we served on you on ________________.

1. ☐ After you meet the conditions of the item marked below, you are no longer required to withhold money from the debtor based on our notice, order, or assignment.
   - a. ☐ You must send all previously withheld money to the Washington State Support Registry at the address below.
   - b. ☐ You must send $ ______________ to the Washington State Support Registry at the address listed below. You may disburse all remaining money as appropriate.
   - c. ☐ You may disburse all withheld money as appropriate.
2. ☐ You are no longer *required* to enroll the children listed below in a health insurance plan based on our notice. However, do not automatically drop these children from coverage. Check with the debtor listed above before taking any action.

Children's Names	Birthdates

Please include the debtor's social security number and account number IN____________ on all payments and correspondence.

____
Date

____
Authorized Representative
DIVISION OF CHILD SUPPORT

If you have questions, contact:
DIVISION OF CHILD SUPPORT

Send all payments to:
WASHINGTON STATE SUPPORT REGISTRY
PO BOX 45868
OLYMPIA WA 98504-5868

TTY/TDD services available for the speech or hearing impaired.

In reply, refer to:
Case #:

RELEASE
[illegible]

BEST COPY AVAILABLE

APPENDIX G: Meeting Schedule

The Working Group met nine times. The first meeting, in March 1999, included a swearing-in ceremony, program briefings, and presentations. The Working Group discussed issues to be contained in the Group's Report to the Secretaries and recommendations to remove the impediments to effective enforcement of medical child support.

At the Working Group's third meeting, in May, the Working Group formed four subcommittees to address various barriers, issues, options, and recommendations between the Working Group meetings. At subsequent meetings of the full Working Group, each subcommittee presented its draft recommendations to the full Working Group for discussion and consideration.

Schedule of Working Group Meetings

Meeting #	Dates	Place	Topic(s)
Meeting #1	March 3-5, 1999	Washington, DC	Swearing In Ceremony, Briefings and Presentations
Meeting #2	April 13, 1999	Washington, DC	National Medical Support Notice
Meeting #3	May 12-13, 1999	Washington, DC	Mission, Goals, Objectives, Priorities, and Organizational Structure developed Subcommittees
Meeting #4	August 12-13, 1999	Chicago, Illinois Hooking onto the National Child Support Enforcement Association Annual Meeting	Subcommittee Reports and Discussion
Meeting #5	October 4-5, 1999	Washington, DC	Discuss and Adopt Recommendations
Meeting #6	November 18-19, 1999	Washington, DC	Finalized Working Group's Recommendations

Meeting #	Dates	Place	Topic(s)
Meeting #7	January 10-11, 2000	Washington, DC	**Finalize Recommendations and Discuss Report**
Meeting #8	March 30, 2000	Washington, DC	**Finalize Recommendations and Working Group's Report**
Meeting #9	June 8, 2000	Washington, DC	**Final Meeting to Vote on Working Group's Report to the Secretaries**

Subcommittees were chaired by Working Group members, assisted by staff leads from HHS and DOL. There were four subcommittees:

- The Notice and Related Issues Subcommittee
- Guidelines Subcommittee
- Coordination of Medical Support, Medicaid, SCHIP, and private Insurance Subcommittee
- Big Picture, Environmental, Tax or "Unintended Consequences" Subcommittee

These four subcommittees of the Working Group met bi-weekly doing research, identifying principles, barriers, and issues, and defining options and early recommendations. Federal Advisory Committee Act (FACA) regulations permit subcommittees to meet in person or by conference call between meetings of the entire Working Group. Subcommittees may develop advice or recommendations to present to the whole Working Group for review and discussion. Federal regulations do not permit subcommittees to make recommendations directly to Federal agencies. Subgroups were not authorized to make binding decisions or perform tasks for which the full Working Group or Agencies is/are responsible. In addition, meetings of such subgroups need not be open to the public and do not require a Federal Register Notice. Each subgroup meeting was attended by at least one employee of each Agency, designated by the Co-Chairs.

APPENDIX G

Subcommittees presented their draft recommendations to the full Working Group at regular meetings for discussion and consideration. The Working Group developed the following strategy to work through issues and recommendations:

1. Subcommittee(s) discuss issues and recommendations to be brought to the full Working Group.
2. The full Working Group discusses subcommittee issues and recommendations.
    - Those identified as needing more work by the subcommittee (substantive re-work/revision) are sent back to subcommittee, to be brought back again to the full Working Group.
    - Those agreed to in content and concept by the full Working Group but identified as needing just minor revision or refinement (e.g., rewording) are sent back to the appropriate subcommittee. Such issues and recommendations are not brought back before the full Working Group for discussion.
    - Those with complete agreement by the full Working Group (consensus recommendation) are finalized.
3. The full Working Group drafts Report of final issues and recommendations.

APPENDIX H: Model Joint Medicaid/SCHIP Application Form

The following document is available on the web at: http://www.hcfa.gov/init/chpelig.htm

September 10, 1998

Dear State Health Official:

This letter is a follow-up to a letter issued by the Department of Health and Human Services on January 23, 1998 regarding opportunities for outreach to uninsured children. First, it highlights the flexibility States have to simplify the application and enrollment processes. Second, it provides clarification of two eligibility-related issues that have come to our attention as a result of the January letter: the provision of Social Security numbers (SSNs) for applicants and non-applicant family members; and establishment of immigration status for non-citizens.

I. Application and Enrollment Simplification

As we indicated in our letter dated January 23, 1998, a major key to successfully enrolling children in CHIP and Medicaid is a simple application and enrollment process. While it is important to maintain program integrity, a burdensome application and enrollment process can be a significant barrier to successful enrollment.

Many States have already begun to simplify their application and enrollment processes. Listed below are actions that States already have taken, as well as some other recommendations that States could adopt to change their current processes and to reduce the stigma and complexity of seeking assistance:

- Shorten application forms and/or use mail-in applications;
- Create joint CHIP/Medicaid applications;
- Use joint Medicaid and CHIP applications;
- Eliminate assets test;
- Allow self-reporting of income by the family with follow-up verification by the State;
- Reduce verification/documentation requirements that go beyond Federal regulation;
- Allow redeterminations to be done by mail;
- Speed up processing;
- Develop a follow-up process for families not completing the application process;

- Establish an effective referral system between the State's CHIP eligibility agency, the Medicaid and maternal and child health programs, schools as well as other Federal and State agencies that serve low-income families;
- Offer phone interviews, or have transportation vouchers to assist individuals in getting to face-to-face interviews;
- Expand outstationing opportunities;
- Increase staff with multi-lingual ability;
- Extend office hours so that applicants do not have to take off work to apply for benefits;
- Take advantage of new options like presumptive eligibility and 12 month continuous eligibility; and
- Try to reduce stigma of seeking public assistance by using techniques such as a different name for program (such as Arkansas' ARKids, Michigan's MIChild, and Connecticut's HuskyCare).

The Federal requirements for the application and enrollment process for Medicaid and for separate SCHIP programs provide a great deal of flexibility to States to design an application and enrollment process that is streamlined and simple, and avoids burdensome requirements for families that apply for benefits. For example, under Medicaid with the exception of obtaining documentation of immigration status for qualified alien applicants and the applicant's Social Security numbers, States have flexibility to determine documentation requirements, including self-declaration of income and assets. In addition, States with separate CHIP programs can streamline and coordinate their application and enrollment processes for CHIP and Medicaid in a number of ways to make it easier for families to apply, including use of a joint application.

The current application and enrollment requirements for Medicaid and separate SCHIP programs are listed in an attachment to this letter. They do not call for families to provide extensive amounts of documentation and information in order to file for benefits. For the most part, they deal in a very broad way with the basic elements of the application and enrollment process, and provide a great deal of flexibility to States to design a process that best suits their needs.

Enrolling America's uninsured children in Medicaid and CHIP is a national priority that requires an aggressive, sustained effort. There are many ways that States can, and are, modifying their processes to make them more user friendly. It is our hope that you will make, or continue to make, a firm commitment to simplify your application and enrollment processes in an effort to reduce barriers to enrolling uninsured children.

II. Clarification of Eligibility Requirements

Provision of Social Security Numbers (SSNs)

Attached to the January 23, 1998 outreach letter was a model joint CHIP/Medicaid application States could use in order to simplify the eligibility process for this new program. One of the pieces of information requested on the model application was a SSN for all family members, including those who were not applying for benefits. We wish to clarify that, under Section 1137 of the Act, a SSN must be supplied only by applicants for and recipients of Medicaid benefits. In all other cases, including non-applicant parents of children applying for Medicaid and children applying for a separate SCHIP program (non-Medicaid), States are prohibited from making the provision of a SSN by another family member a condition of the child's eligibility. This also applies to other members of the household whose income might be used in making the child's eligibility determination.

A revised joint application form for CHIP/Medicaid children is enclosed. As you will see, the form now requires a SSN only for children applying for Medicaid benefits. For children applying for a separate SCHIP program (non-Medicaid) and members of the household not applying for benefits, the SSN is indicated as being optional.

Some States use parents' SSN as a means of verifying family income in the process of making an eligibility determination. While the statute does not require disclosure of the SSN for non-applicants, voluntary disclosure by the parent may facilitate the verification of income and contribute to a speedier and more accurate determination of the child's eligibility. States may advise parents and other household members of this as long as they do so in a manner that does not coerce provision of the SSN or deter application for benefits. Once more, we wish to clarify that States have no legal basis for denying an application based upon the failure to supply the SSN for verification purposes.

III. Establishing Citizenship and Immigration Status of Non-Citizens

Children who are citizens and who are applying for either Medicaid or a separate SCHIP program may establish their citizenship on the basis of self-declaration; States are permitted to require further verification as a condition of eligibility. Children applying for either program who are qualified aliens must present documentation of their immigration status, which States must verify using systems established for that purpose. The citizenship or immigration status of non-applicant parents (or other household members), however, is irrelevant to their children's eligibility. States may not require that parents disclose this information.

There are both statutory and programmatic bases for our policy. Under the statute (Section 1137 of the Act), there is no authority for requiring individuals other than those applying for benefits to provide their SSNs or to document their immigration status. Furthermore, the Privacy Act makes it unlawful for a State to deny benefits to an individual based upon that individual's failure to disclose the SSN, unless the disclosure is required by Federal law or was part of a Federal, State, or local system of records in operation before January 1, 1975. States may only seek the SSN of these individuals on a strictly voluntary basis. The CHIP law does not require applicants to provide SSNs and the Medicaid law only requires it for applicants and recipients of Medicaid benefits.

From a programmatic point of view, asking non-applicants for their SSNs or evidence of immigration status may discourage immigrant parents, who may not wish to disclose information about themselves, from applying for benefits on behalf of their children who are U.S. citizens. When this occurs, the children are, in effect, denied access to medical care that they both need and are eligible for under the law.

We encourage States to actively provide information to adults applying for benefits on behalf of their children to inform them that their children's eligibility for Medicaid or CHIP is not contingent on disclosure of a parent's SSN (or lack thereof), or on information about non-applicant parents' immigration status.

If you have questions or suggestions on any of these eligibility-related issues and the use or adaptation of the model form and guidance attached, please contact your HCFA regional office staff.

Sincerely,

Sally K. Richardson
Director

Attachments

cc:
All HCFA Regional Offices
All PHS Regional Offices

HHS Regional Directors

Lee Partridge
American Public Human Services Association

Nolan Jones
National Governors Association

Joy Wilson
National Conference of State Legislators

Cheryl Beversdorf
Association of State and Territorial Health Officials

Mary Beth Senkewicz
National Association of Insurance Commissioners

MODEL JOINT APPLICATION FOR CHIP/MEDICAID FOR CHILDREN

[Revised 8/31/98]

Purpose: The attached model joint application can be used for both the Children's Health Insurance Program (CHIP) and children's Medicaid eligibility (under the children's poverty level related groups). States could allow individuals to use this form to apply for both programs and the information on this form would be sufficient for determining which program a child is eligible for. It includes only the information that is required in all circumstances, and it is provided as a base form that a State can adapt to meet its own needs. As presented, the form is suitable for completion by an intake worker. Modifications would be required to make the form suitable for direct completion by the applicant.

Screening: This application will meet the statutory requirement in Title XXI that States identify children who are eligible for Medicaid.

NOTE: Non-State employees cannot determine Medicaid eligibility. Therefore, in a State that has contracted out the process of CHIP eligibility determination (i.e., determinations are performed by non-State employees), this model application would have to be modified for use as a pure screening form (or a combination of an application for CHIP and a screening form) by removing all references to it as a Medicaid application. The statement about the use of the Social Security Number [33] still would be required. The inclusion of the section on rights and responsibilities [34] (but omitting any reference to Medicaid), however, would be at State option.

If the form were so modified, in order to permit the information on the form to be submitted for use in making a Medicaid determination, the eligibility workers could provide a separate page to be completed by those whom the screen indicates are Medicaid-eligible. On that page, the individual should consent to submission of the information as part of a Medicaid application, and accept the rights and responsibilities outlined in this model (including a statement under penalty of perjury that the information provided on the "attached screening form" or "attached CHIP application" is correct). Once this page is completed, the form could be forwarded to the State for a Medicaid eligibility determination.

Mandatory Information About Medicaid: If a State uses a joint CHIP/Medicaid application and denies the Medicaid application, then the State must thoroughly inform the individual about the availability of Medicaid and his or her right to apply for Medicaid on a basis other than as a poverty-level child. This includes an explanation of the Medicaid program and the various eligibility groups, the advantages of Medicaid over CHIP and information about how and where to apply for Medicaid.

Federal Verification Requirements: Under Federal law, there are no verification requirements pertaining to eligibility for the children under Medicaid other than those related to alien status of non-citizens, the post-eligibility requirements of §1137 pertaining to use of the individual's Social Security Number and an income and eligibility verification system. Eligibility of a citizen child may be established on the basis of self-declaration under penalty of perjury. States are permitted, however, to require further verification as a condition of eligibility.

Section 1137's requirement for furnishing a Social Security number applies only to the applicants for and recipients of Medicaid. It does not apply to the parents of Medicaid applicants, nor does it apply to a State-run Children's Health Insurance Program that is separate from the State's Medicaid program. The Privacy Act, § 7 of Public Law No. 93-579, 88 Stat. 1896, makes it unlawful for a State to deny benefits to an individual based upon that individual's failure to disclose the Social Security number unless the disclosure is required by Federal law or was part of a Federal, State, or local system of records in operation before January 1, 1975. Since the new CHIP program does not require that Social Security Numbers be supplied and the Medicaid program requires it only for applicants and recipients, States may seek these account numbers from applicants for a non-Medicaid CHIP program only on a strictly voluntary basis.

Additional Simplification of Medicaid Eligibility Determination: If the total gross income of the family is at or below the applicable Medicaid income standard, the questions in the shaded areas need not be answered. The individual is obviously income eligible for Medicaid without further information.

Explanation of Certain Fields: There are some questions on the application that may not elicit all the information needed to make a determination. Under certain circumstances, additional information will be required. For example:

- If the answer to the question about citizenship [18] is no, actual status will need to be determined, official documents submitted, etc.
- If the child has insurance [22] and is Medicaid-eligible, information about the insurance company and policy number will be needed; and
- If the child had medical bills in the last 3 months [32] and is Medicaid-eligible, eligibility information for the last three months will be needed to establish retroactive eligibility, in addition to information about the bills.

In addition, the question concerning employment by a public agency in the State [25] is only needed for CHIP eligibility and is not needed for Medicaid. This field does not ask directly about the availability and nature of health insurance, on the assumption that the eligibility worker would have access to a list of public agencies that offer State health insurance of the type that would preclude CHIP eligibility. If this is not the case in your State, this field would need to be expanded.

Examples of State Modifications:

- A State may wish to include voter registration; or
- A State may want to use this as an application for Medicaid for the adults, which would require additional information about the adults and stock affidavits concerning assignment of rights and pursuit of support.
- A State will need to add a question concerning each individual's resources (assets) if:
    - the State applies a resource test for the poverty level children; or
    - the State has not chosen to cover children born before 10/1/83 under the poverty level group AND the State applies a resource test for the optional group of categorically needy children ("Ribicoff children").

APPENDIX H

-- SAMPLE --
CHILDREN'S HEALTH INSURANCE PROGRAM / MEDICAID JOINT APPLICATION FORM [Revised 8/31/98]

I. Person Applying for the Child or Children					
Name [1] FIRST MIDDLE LAST	Home Phone [2]	Work Phone [3]			
Home Address [4] Street	Apt. # [5]	City [6]	State [7]	Zip [8]	County [9]
Mailing Address (if different from above) [10] Street	Apt. # [11]	City [12]	State [13]	Zip [14]	County [15]

II. Family Members Living in the Home (Attach extra sheet if needed)						
Children (under 19) living in the home NAMES [16]	Date of Birth [17]	Citizen (Yes or No -- if no, see also attachment) [18]	Social Security Number **[required for applicants -- otherwise optional]** [19]	Mother's Name [20]	Father's Name [21]	Covered by Health Insurance other than Medicaid [Yes or No] If yes, what insurance? [22]

Adults living in the home NAMES [23]	Social Security Number **[optional]**[24]	If employed by a public agency in the State, what agency? [25]

III. Income and Child Care Payments

List all the Income Received by Family Members Listed Above (Attach Extra Sheet if Needed)

Name of person(s) working or receiving money?[26]	**Who provides the money?**[27] Employer, program or person	**How Often?**[28] Weekly, twice a month, monthly	**What amount?**[29] Before taxes or any deductions
1.			
2.			
3.			

*Be sure to include all sources of gross income (before taxes) such as wages, dividends & interest, TANF, SSI annuities, pension, disability, child support, alimony, cash gifts, & other unearned income.

List the payments made for child care (or care for an adult who cannot care for himself) so that someone in your household can work?[30]

Name of person(s) who works	**Name of Person Care For**	**Under Age 2?**	**How Often?**	**What amount?**
		Yes ☐ No ☐		

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APPENDIX H

IV. Medicaid Questions	
Is any child[31] Pregnant: Yes ☐ No ☐ In an Institution: Yes ☐ No ☐	**Do any of the children have unpaid medical bills from the last 3 months?**[32] Yes ☐ No ☐

Social Security Number (SSN)[33]

If you are applying for Medicaid for a child, you are not required to provide your own Social Security Number (SSN), but we must have the child's SSN in order for the child to receive Medicaid. If you are applying for CHIP [State-specific program name] for a child, you are not required to provide either your own or the child's SSN. If you are applying for Medicaid for yourself, you must provide your SSN. This policy is dictated by section 1137(a(1) of the Social Security Act and the Medicaid regulations at 42 CFR 435.910. The Medicaid agency will use the SSN to verify your income, eligibility, and the amount of medical assistance payments we will make on your behalf. It is possible that the Medicaid agency will also use the SSN to determine another person's right to Medicaid or to comply with Federal law requiring that we release information from Medicaid records. The information may be matched with the records in other agencies, such as the Social Security Administration or the Internal Revenue Service. These matches may be done by computer or on an individual basis.

Rights and Responsibilities[34]

I agree to the release of personal and financial information from this application form and supporting documents to the agencies that run these programs so that they can evaluate it and verify eligibility. I understand that the agencies that run the programs will determine confidentiality of this information according to the federal laws, 42CFR 431.300-431.307.1, and any applicable federal and state laws and regulations.

Officials from the programs that I, or members of my household, have applied for may verify all information on this form.

I understand that I must immediately tell the Medicaid agency about any changes in information on this form.

I understand that I may be asked to provide additional information.

I understand my eligibility will not be affected by my race, color, national origin, age, disability, or sex, except where this is required by law.

I understand that this application is an application for one kind of children's health benefits under Medicaid and is not a full Medicaid application. I understand that if I am not found eligible for this kind of children's health benefits under Medicaid, I may be eligible for Medicaid benefits on some other basis and have a right to complete a full Medicaid application.

I have the right to appeal any decisions made by a local Medicaid program. Information on the appeals process can be obtained from the local Medicaid agency.

I understand that anyone who knowingly lies or misrepresents the truth or arranges for someone to knowingly lie or misrepresent the truth is committing a crime which can be punished under federal law, state law, or both. I understand that I may also be liable for repaying in cash the value of the benefits received and my be subject to civil penalties.

I certify under penalty of perjury that everything on this application form is the truth as best I know.

Signature [35] **Date**

Date Received by Agency [36]

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Application and Enrollment Requirements for Medicaid and Separate SCHIP

1. Requirements for Separate State (non-Medicaid) CHIP

If a State chooses to develop a separate State (non-Medicaid) CHIP program, the only Federal requirements for the application and enrollment process for CHIP are:

- A screening and enrollment process designed by the State to ensure that Medicaid eligible children are identified and enrolled in Medicaid; and
- For qualified aliens, verification of applicant's immigration status with INS.

2. Requirements for Medicaid

The Federal requirements for the application and enrollment process for Medicaid (including CHIP-related Medicaid programs) are explained in 42 CFR 435.900ff. Specifically, States must:

- Give individuals the opportunity to apply for Medicaid without delay. Pregnant women and infants must have the opportunity to apply for Medicaid at required outstation locations other than welfare offices.
- Require a written application on a form prescribed by the State Medicaid agency and signed under a penalty of perjury. The application must be filed by the applicant, an authorized representative, or if the applicant is incompetent or incapacitated, someone acting responsibly for the applicant.
- Provide written (or oral, if appropriate) information to all applicants on Medicaid eligibility requirements, available services, and the rights and responsibilities of applicants and recipients. The State also must have pamphlets or bulletins that explain the eligibility rules and appeal rights in simple, understandable terms.
- Obtain the Social Security number (SSN) of the applicant. (Note that the SSN cannot be required of other family members who are not applying for Medicaid).
- If the applicant is a qualified alien, obtain documentation of satisfactory immigration status and verify immigration status with INS. (Note that this requirement does not apply to parents if the parents are not applying for Medicaid).
- Take action on applications within a time standard set by the State (not to exceed 45 days for individuals who apply on a basis other than disability) and inform the applicant about when a decision can be expected.
- Record in each applicant's case record facts to support its eligibility decision.
- Send a written decision notice to every applicant. If the application is denied, the notice must include the reasons for the denial, the specific regulations supporting the action and an explanation of the applicant's right to a hearing.

It also is important to note that the State's application and enrollment process must be consistent with our data collection requirements.

Federal law requires no verification of information pertaining to eligibility for children under

Medicaid other than the requirement for verification of immigration status of qualified aliens,

and the post-eligibility requirement in Section 1137 for an income and eligibility verification

system (IEVS). Under IEVS, the State must request information from other Federal and

State agencies to verify the applicant's income and resources. The applicant must be informed

in writing, at the time of application, that the agency will be requesting this information.

Last updated September 17, 1998